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PSYCHOLOGICAL BRANCH

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ANNUAL REPORT - 30 JUNE 1945

Army Air Forces
Regional and Convalescent Hospital
Miami District

MIAMI BEACH FLORIDA

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A N N U A L R E P O R T

O F

PROGRAM PLACEMENT AND PSYCHOLOGICAL BRANCH

CONVALESCENT SERVICES DIVISION

U.S. ARMY AIR FORCES REGIONAL

AND CONVALESCENT HOSPITAL,

MIAMI DISTRICT

Miami Beach 40,

Florida

Clearance Number

AAF - AS - SP21

June 1945

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P R E F A C E

The history of a complex institution is often a history of enthusiasm for a new mission, of groping for the means to implement the mission, of dissatisfaction with seemingly meager results, of disillusionment with self and situation, and of continued striving to clarify objectives and develop methods. It is often helpful, after some progress has been made toward the clarification of aims and development of means, for those involved in the work concerned to take stock of the direction of their efforts and the results of their labors. In doing so they may, if they have labored well, gain new insight into their mission and a new perspective concerning their success, and thus be aided in carrying on with increasing effectiveness. The preparation of this Annual Report has come at such a time in the development of this Branch. It is hoped that some of the initial enthusiasm, subsequent groping and dissatisfaction, and new insight and vigor are reflected in this account, preparation of which has helped to crystallize certain developments. They should be of interest, not only to aviation and clinical psychologists, but also to other Convalescent Hospital personnel, and in particular, to the Directors of Professional and Convalescent Services and chiefs of related branches such as those who, in this Hospital, have contributed materially to clarification and implementation of the objectives of this Branch.

This report is the result of the combined efforts of all personnel of this Branch, each Section preparing its chapter for coordination by the Administrative Section. Art work, printing, photography, and binding were accomplished by convalescent patients as a patient project with the assistance of Education Branch officers and men. Typing of original copy and much of the stencil work was done by the Branch stenographer, and by a civilian typist borrowed for the preparation of this report through the efforts of Lt. Col. D. F. Armstrong, Director of Personnel Administration and Base Services, who also secured additional typing help for stencil cutting.

Donald E. Super

DONALD E. SUPER
Captain, AC
Officer-in-Charge

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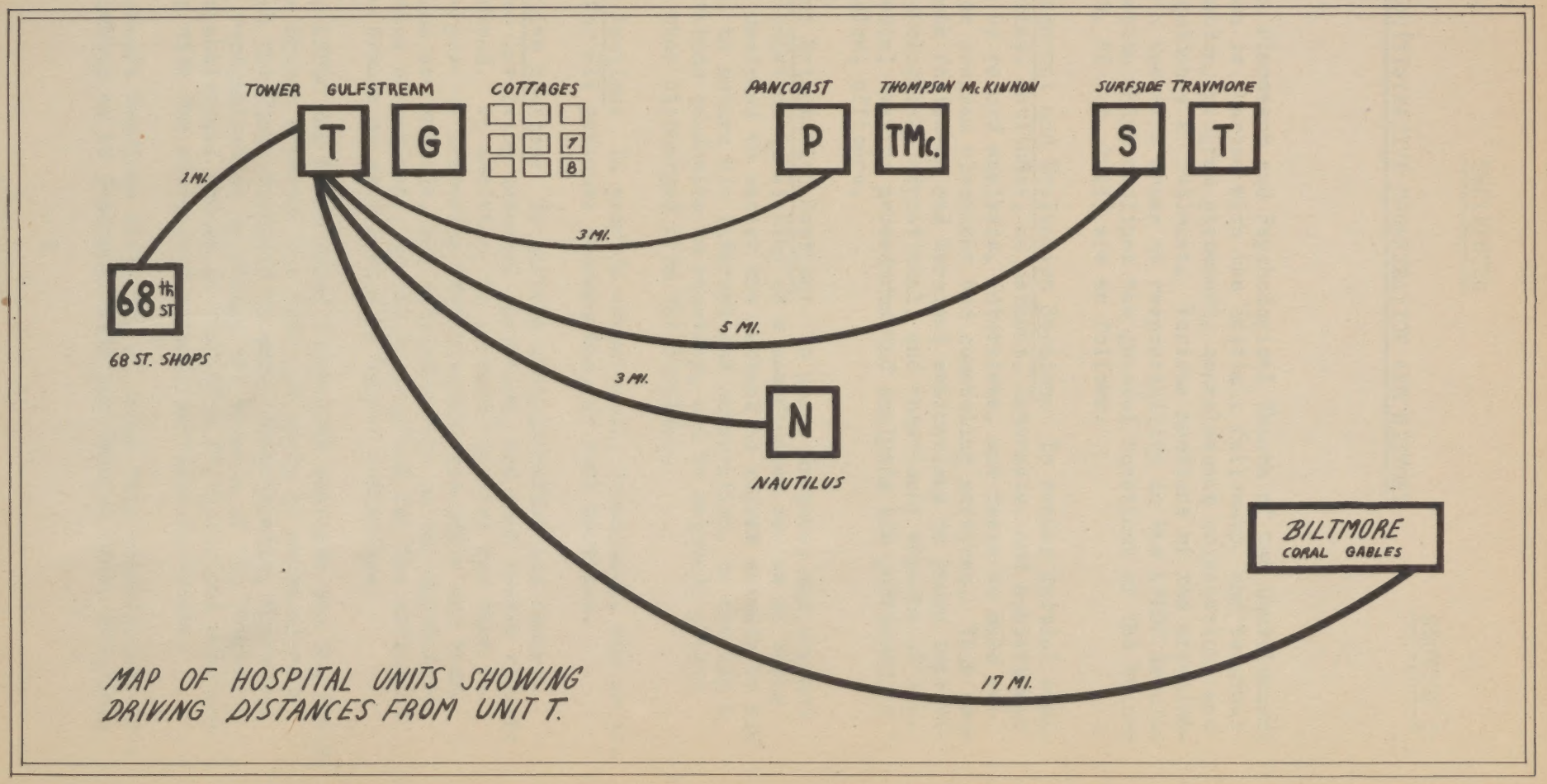

MAP OF HOSPITAL UNITS SHOWING
DRIVING DISTANCES FROM UNIT T.

SECTION I

ADMINISTRATIVE ORGANIZATION AND HISTORY

Mission:

The Program Placement and Psychological Branch of the Convalescent Services Division is charged with the initial, follow-up, and terminal study and evaluation, program placement, convalescent orientation, and counseling and guidance of patients. Various sections of the organization charged with specific areas of responsibility in the AFPDC Regulation on organization which outlines the general functions of the Branch (AFPDC Reg 20-19, 28 Oct. 1944) are as follows:

Program Placement and Evaluation Section: To render initial evaluation of abilities, aptitudes, adjustment, interests, and achievement of all patients by record analysis, interviews, and tests to make recommendations for program placement and counseling services. This section also conducts follow-up and terminal evaluations to gauge improvement in the psychological, educational, and vocational aspects of convalescence. Special testing procedures and analysis are performed as requested by medical officers.

Convalescent Orientation Section: To plan, prepare, and conduct convalescent orientation consisting of a coordinated series of talks and discussions designed to assist the patient to adjust quickly to his new environment, to secure his interest and cooperation, to develop a sound mental attitude conducive to recovery, and to maintain proper military morale when discharged from the hospital.

Counseling Section: To provide educational, vocational, and personal counseling for all patients recommended for such services.

Administrative Section: To perform administrative and record-keeping functions involving internal operation, and such Branch reports as might be required. In addition, to conduct research and make reports for the purpose of improving psychological procedure and techniques, developing new methods, and obtaining data on the psychological characteristics of patients, as may be required for the efficient operation of the Branch or as directed by higher authority.

The revised AFPDC Reg 20-19 dated 9 May 1945 rescinds the Reg 20-19 under which this Branch operates but does not apply to multi-mission stations of which the Miami District is one. Consequently, there has been no overall reorganization to change the mission of the Program Placement and Psychological Branch to that of a Psychological Services Branch, on a par with the other professional services divisions.

The Convalescent Services Division, of which this organization is a branch, was activated on 15 September 1944 per General Order #25, Hq.,

AFPDC, dated 28 September 1944. Actual operations of the Branch, however, did not begin until 2 October 1944. On 4 October 1944, the Branch began to function with the arrival of Major Edward I. Strongin. Prior to his arrival at Miami Beach, Major Strongin had spent some time at Hq., AAFPDC, in preparation for his assignment as Chief of the Branch. With the orientation he received at Headquarters, Major Strongin was able to initiate the activities of the organization although no written regulations or directives existed. In addition to the major, 2 officers and 2 enlisted men were assigned to the Branch early in October.

The Branch was located at the Tower-Gulfstream Hotels, a unit of the AAF Convalescent Hospital some 3 miles from the headquarters. Space was provided in the basement of the Gulfstream Hotel and consisted of a long corridor with 6 small rooms for operations.

With insufficient personnel, inadequate space, and only a general, unwritten conception of its mission, the Branch began to process patients at Unit T on 9 October. Processing consisted of assembling the patients who had arrived at Unit T the previous day in one of the small offices and orientating them to the Convalescent Program. Other branches of the Convalescent Services Division were already in operation on a small scale, and this initial orientation was designed to interest patients in the activities of these other branches. Patients were scheduled for placement and evaluation interviews although the main purpose of these was to acquaint the patient with the hospital program at the conclusion of the orientation period. Results of the interviews were recorded on temporary forms which were filed for possible future use. Placing of patients in the program presented a problem because of the limited number of activities available. However, in spite of the lack of space, equipment, and personnel throughout the Convalescent Program, a modicum of success was achieved in placing patients in activities.

A series of 12 lectures covering the field of mental hygiene and applied psychology as it might effect patients and military personnel in general, was instituted in anticipation of the regulation which later arrived, requiring that a coordinated series of talks (continuous orientation) be developed and presented to patients. The directives required that the orientation consist of 5 weeks of lectures, 2 hours per week. However, local conditions which did not permit most patients to remain at this unit for 5 weeks, and the lack of convalescent activities, made it desirable that the orientation course be completely offered in a shorter period of time. Accordingly, a series of ten lectures given during two consecutive weeks was instituted.

In October 1944 a Separation Program was established in the Convalescent Services Division as part of the Psychological Branch. Conferences were held with the American Red Cross, representatives of the local USES and the Veterans' Administration, the Personal Affairs Officer,

and the secretary of the CDD Board of the hospital to determine areas of responsibility and coordinate services. The only available space for the program was one room of the Pancoast Hotel (Unit P) located some 3 miles from Unit T and directly across the street from the Headquarters Building. By the time the personnel assigned from this Branch to do separations work were settled in their new space, more enlisted and officer personnel arrived for duty. With a backlog of 40 patients awaiting discharge, the first separations activities supervised by this Branch were conducted during the last week in October with 9 patients participating.

By November the Branch personnel consisted of 4 officers and 9 enlisted personnel of whom 4 were members of a WAC detachment on Miami Beach assigned to this Branch because of their classification as Personnel Consultant's Assistants. It was found that their maturity and previous civilian experience as social workers made them valuable interviewers. With the exception of one enlisted man and the four members of the WAC, all personnel were procured by Hq., AAFPDC.

With the increased personnel and general growth of the Convalescent Services Division, the lack of adequate space for Branch operations became a major problem. After numerous surveys of available space, the Chief of the Convalescent Services Division assigned an eight room cottage on the grounds of Unit T for Psychological Branch activities. The Branch operated in this location (cottage #5) for three days when it became necessary to halt operations while the cottage was redecorated and painted. At the conclusion of the renovation, operations were begun again, but by the end of a week another move was arranged into two cottages 7 & 8. Operations there did not begin for another week because of renovations. The additional space made it possible to move the Separations Service from Unit P to Unit T. The space available was considered to be completely adequate, consisting of space for group work with patients, interviews, and office operations.

A serious lack was the inability to obtain stenographic help, and it was necessary that two of the officers who could type devote part of their time to the preparation of reports, letters, and routine typing for the division. This situation was somewhat corrected with the arrival of one enlisted man who was assigned to the Administrative Section and acted as clerk-typist-stenographer.

Initially, the Branch was divided into four sections:

The Administrative and Research Section which was charged with the general administration of the Branch, submission of reports and responsible for work on psychological research projects as ordered by higher headquarters, amd conducting such individual research as was deemed appropriate to this particular situation;

The Orientation Section whose functions were broken down into an initial orientation which welcomed the patient to the hospital, a supplementary orientation which orientated the patient to the Convalescent Program, and a continuous orientation which consisted of a series of lectures dealing with topics of applied psychology designed to assist the patient in making a rapid adjustment to his return to continental United States and such other problems as might be related to his individual adjustment;

The Counseling Section had as its chief functions personal counseling and vocational and educational counseling; personal counseling is designed to discuss with the patient any personal problem he might have and make an attempt to help him solve it; vocational and educational counseling is devoted to advising and working out for patients who are about to be separated from the service, a program to help them adjust rapidly to their new civilian status, finding a job, returning to school, and other topics which might be pertinent.

The Program Placement and Evaluation Section rendered initial evaluation of abilities, aptitudes, adjustments, interests, and achievements of all patients by record analyses, interviews, and testing, and made recommendations for program placement and counseling services. This section also conducted follow-up and terminal evaluations to gauge improvement in the psychological, educational, and vocational aspects of convalescence. Special procedures and analyses were performed as requested by medical officers.

On 6 November 1944 a copy of AFPDC Regulation 20-19, dated 28 October 1944, was received at the Convalescent Services Division and the activities of this Branch were readjusted in accordance with information contained in par. 24 of above regulation (Organization Chart, Table I).

Early in January Major Strongin was trenaferred to the Convalescent Hospital at Plattsburg, New York. Captain Donald E. Super, then Ass't. OIC at the Psychological Branch, Redistribution Station #2, Miami Beach, was transferred to this Branch as OIC.

In mid-January, with the opening of a Convalescent Program at Unit N, this Branch began Program Placement operations at that Unit. Initially, because of a large backlog of patients to be enrolled in the program, it was necessary to conduct a mass orientation to the convalescent activities and a very hasty placement interview. However, within approximately one week, all backlog patients were enrolled and one enlisted man on full time and one officer on part time were assigned to Unit N to orient patients to the program and place them. Because the patients at Unit N were definitive cases and because most Unit N operational fatigue cases eventually were transferred to Unit T to complete their convalescence, it was not felt necessary to institute the continuous orientation lectures. Thus, the only operations conducted at Unit N were, and

are, Program Placement and Initial Orientation.

Early in March the Convalescent Services Division began to operate at Unit B with the completion of buildings to house activity facilities. Again, as had been the case at Unit N, a backlog of patients was handled and one officer and two enlisted men were permanently assigned to operate the Branch at that Unit. Together with the placement functions there was instituted a continuous orientation lecture series.

On 19 March, because of the pressing need for diagnostic psychological testing at Unit B, one additional officer was assigned to that Unit and used the services of one of the enlisted men already assigned on a part-time basis.

At this time there were added to the hospital two more hotels under the designation of Unit S. Vocational and Educational Counseling activities, formerly performed at Unit T, were moved to Unit S which was set up to handle separations. One officer and four enlisted men were moved there as were other branches and offices which were concerned with separations work. No other Branch operations were organized because Unit S had no activity facilities, and since its incorporation as one of the hospital units, it has housed only a few patients for extremely short periods of time. Although the Separations activities are no longer under the supervision of this Branch, personnel originally assigned continue to operate as a service organization for the Personal Affairs Branch.

There have been no further changes in the organization except for the shifting of personnel. Par. 2 of AFPDC Regulation 20-19 dated 9 May 1945 indicates that that regulation does not apply to this station. AFPDC Ltr 80-56 dated 9 May 1945 and the PD Communique for 31 May 1945 are written as though this Branch were intended to be a Professional Service but the local interpretation of the directives is that the Branch continue as part of the Convalescent Services Division. However, certain aspects of this Branch's work, for example, the Counseling and Testing Services for the Personal Affairs Branch, and clinical testing for Psychiatric Services have developed Branch functions to the point of providing services for the entire hospital organization rather than for the Convalescent Services Division exclusively.

Organization charts reflecting major changes in personnel assignments and functions follow.

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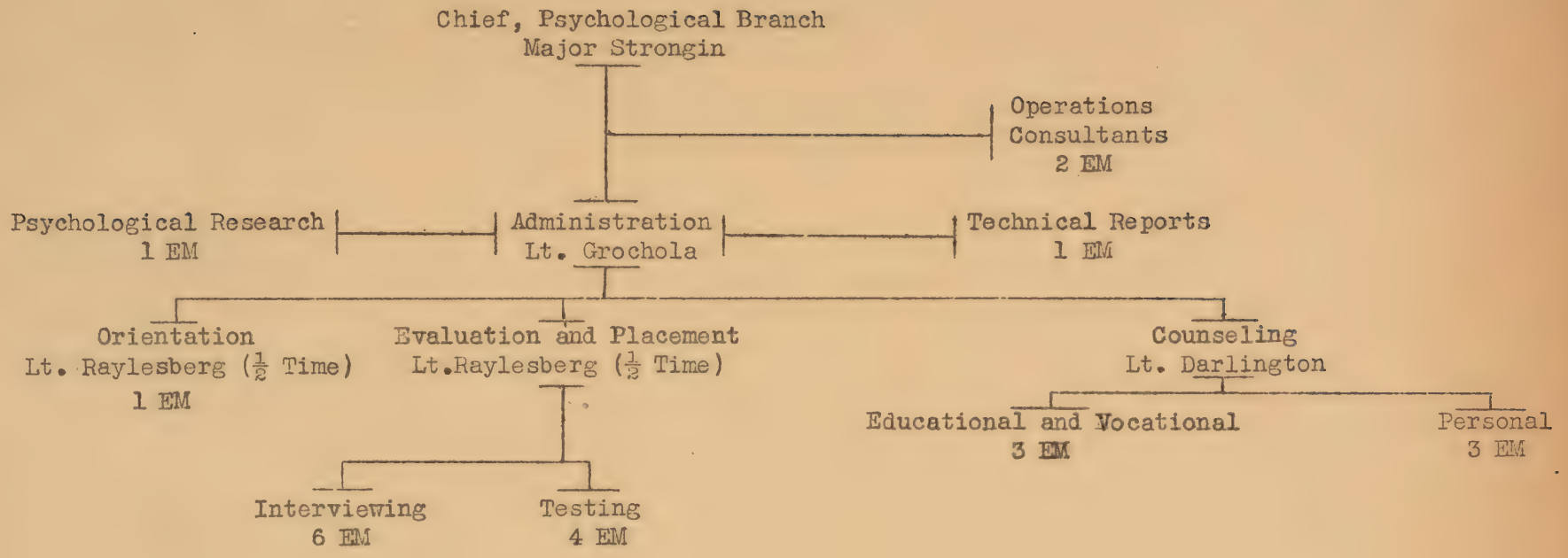
All Operations
at Tower

ORGANIZATION CHART
TABLE I

30 November, 1944



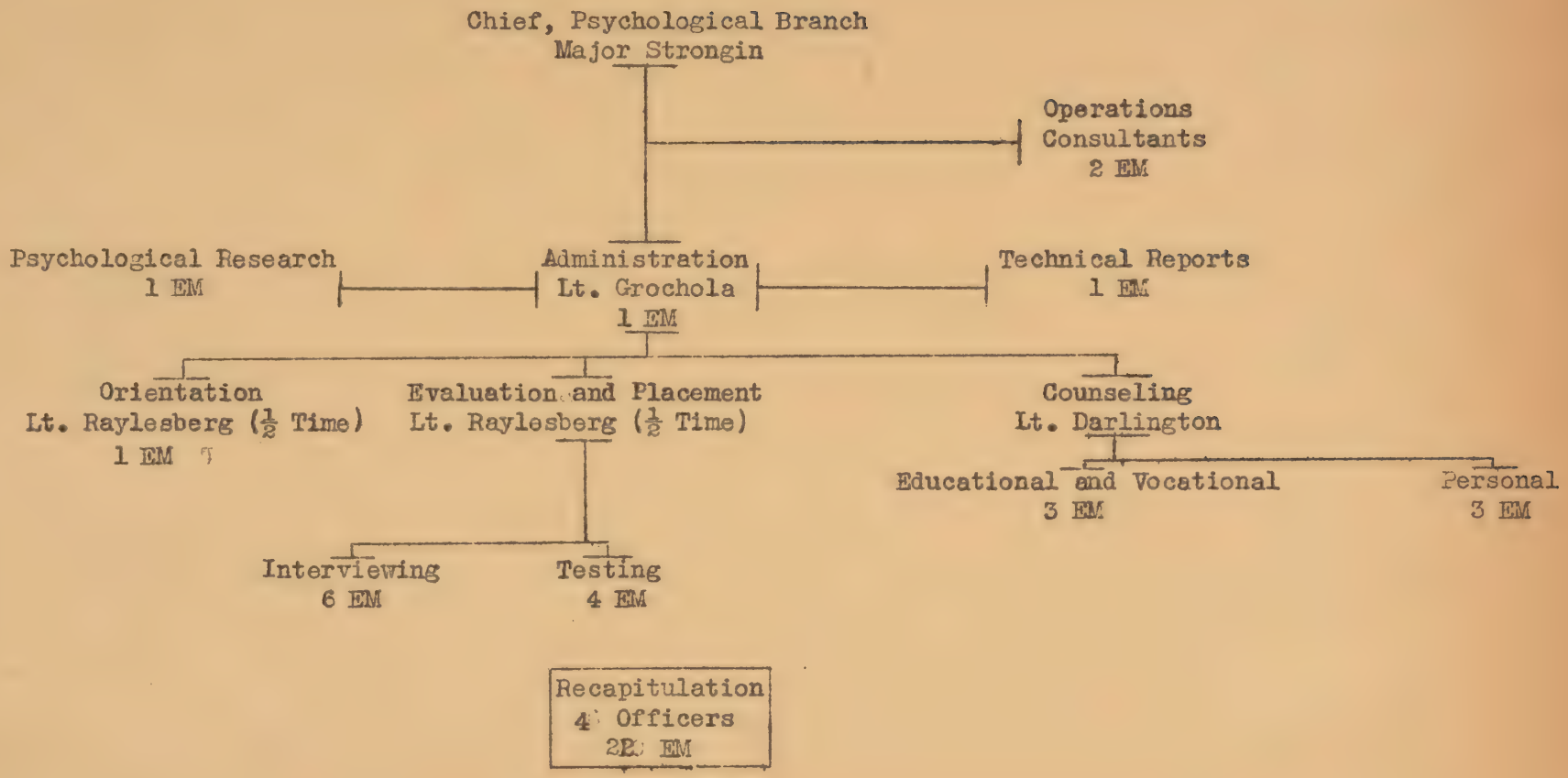
Recapitulation
4 Officers
21 EM

RESTRICTED

All Operations at Tower

ORGANIZATION CHART
TABLE II

31 December, 1944



RESTRICTED

T - Tower
B - Biltmore
N - Nautilus

ORGANIZATION CHART
TABLE III

31 January, 1945

OIC Psychological Branch
Capt. Super

Administration
Records and Reports
Lt. Grochola
4 EM

Orientation
Lt. Raylesberg (½ Time)
1 EM

Evaluation and Placement
Lt. Delman

Interviewing
4 EM T
1 EM N

Testing
4 EM

Vocational and
Educational Counseling
Lt. Darlington
3 EM T
1 EM B

Research
Lt. Raylesberg (½ Time)
2 EM

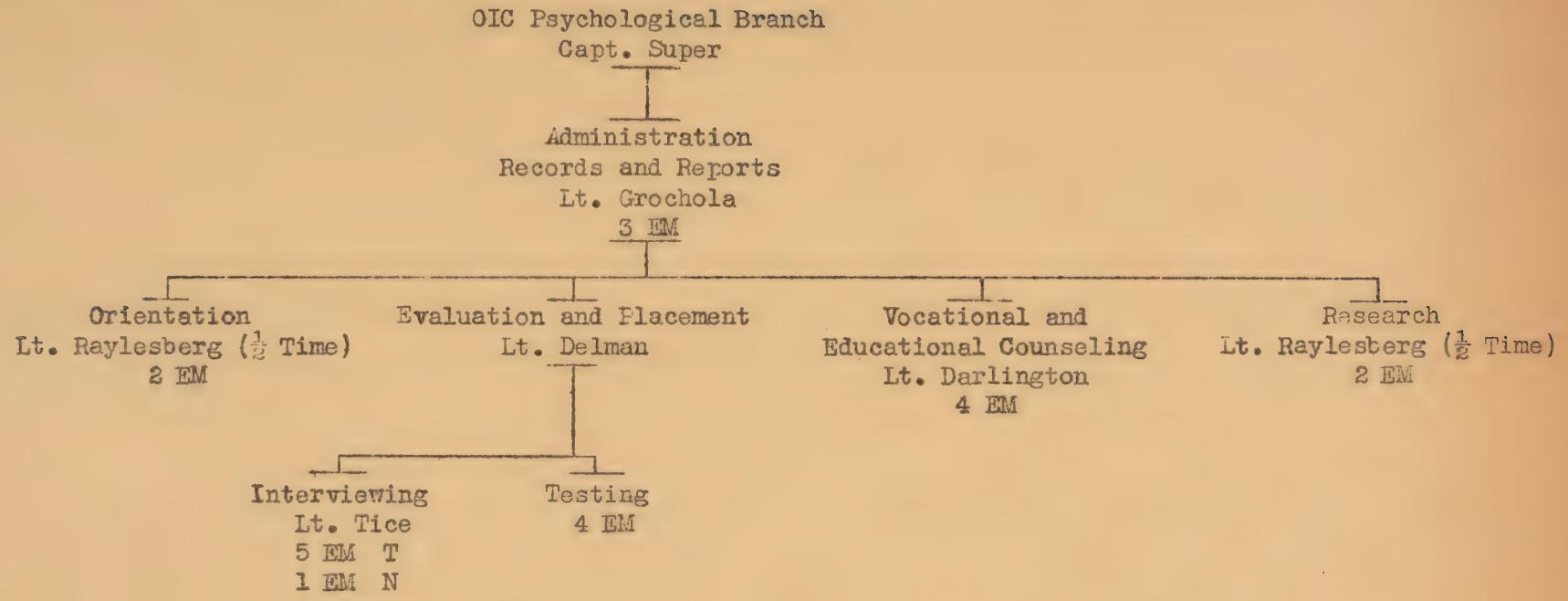
Recapitulation
5 Officers
20 EM

RESTRICTED

T - Tower
N - Nautilus

ORGANIZATION CHART
TABLE IV

28 Feb., 1945

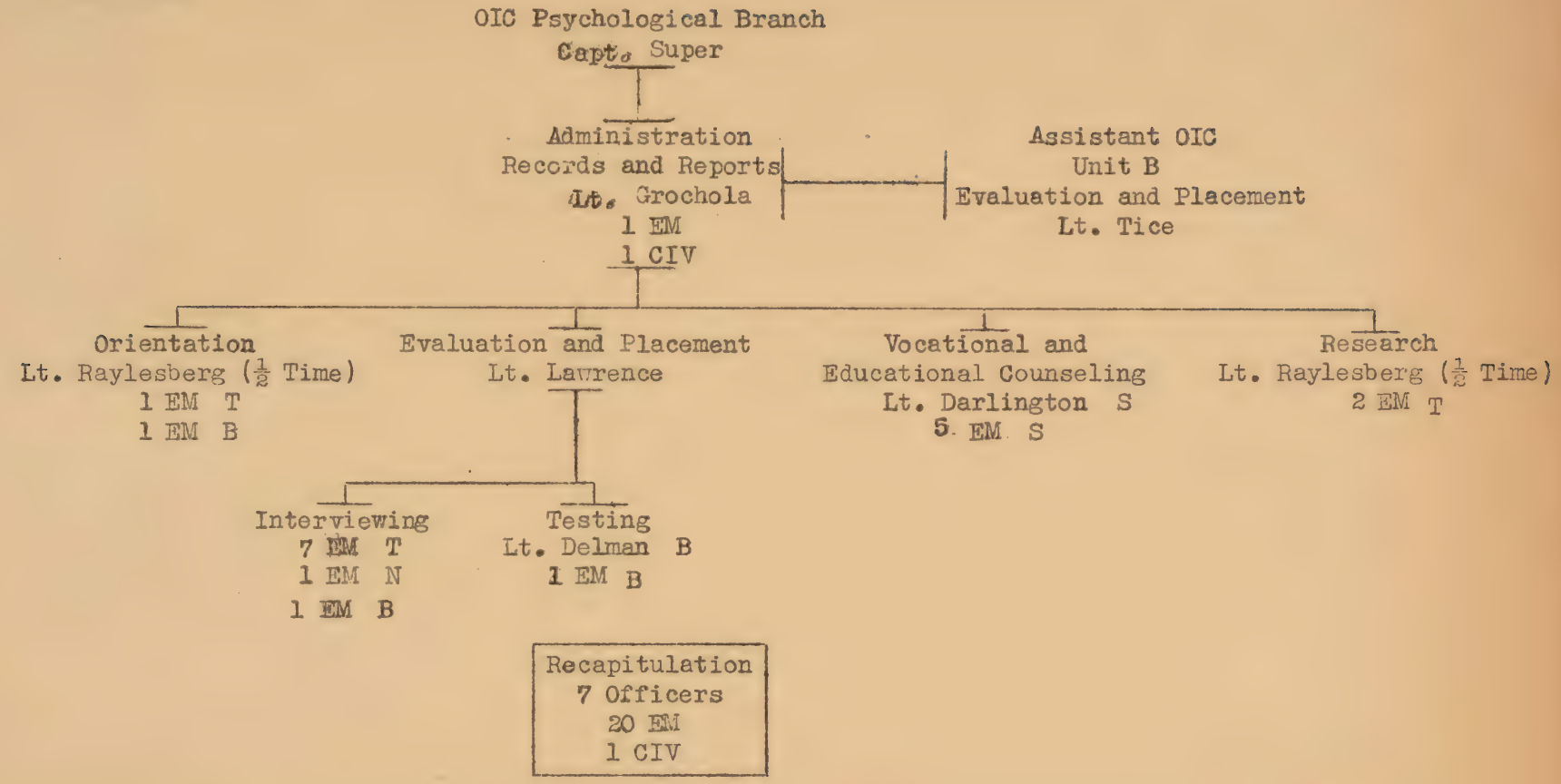


Recapitulation
6 Officers
21 EM

T - Tower
B - Biltmore
N - Nautilus
S - Surfside

ORGANIZATION CHART
TABLE V

31 March, 1945

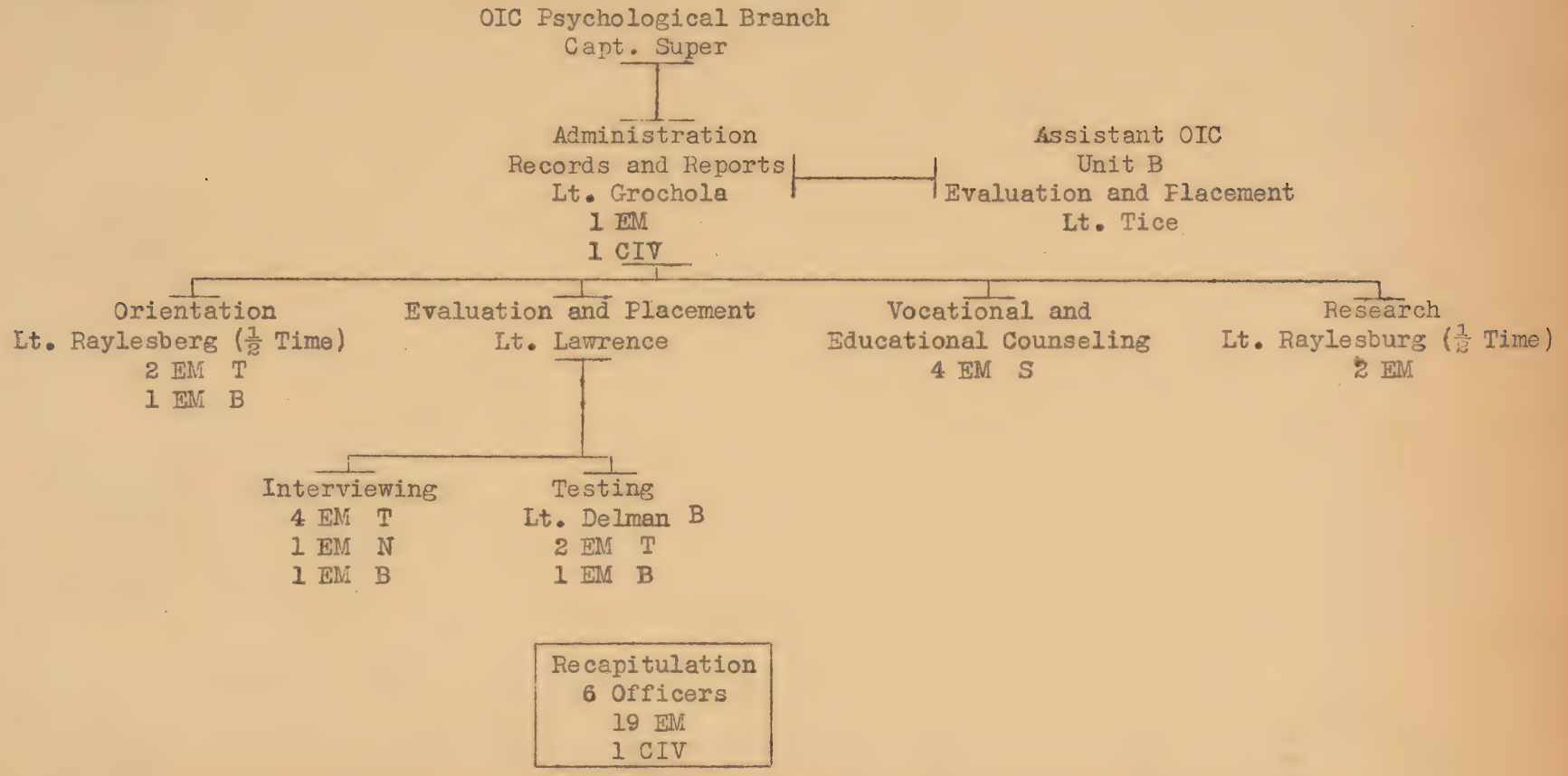


RESTRICTED

T - Tower
B - Biltmore
N - Nautilus
S - Surfside

ORGANIZATION CHART
TABLE VI

30 April, 1945



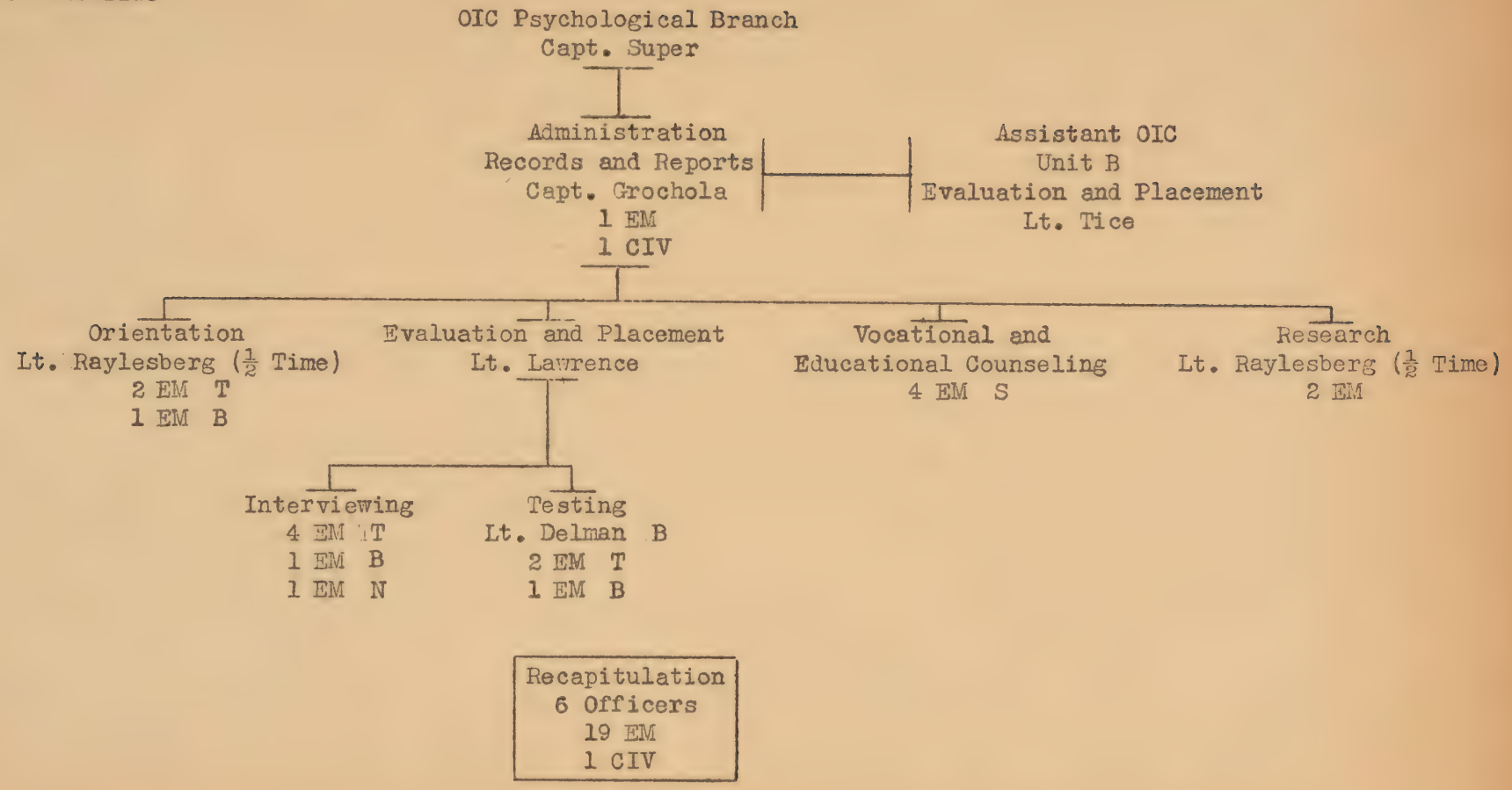
RESTRICTED

RESTRICTED

T- Towers
B- Biltmore
N- Nautilus
S- Surfside

ORGANIZATION CHART
TABLE VII

31 May, 1945

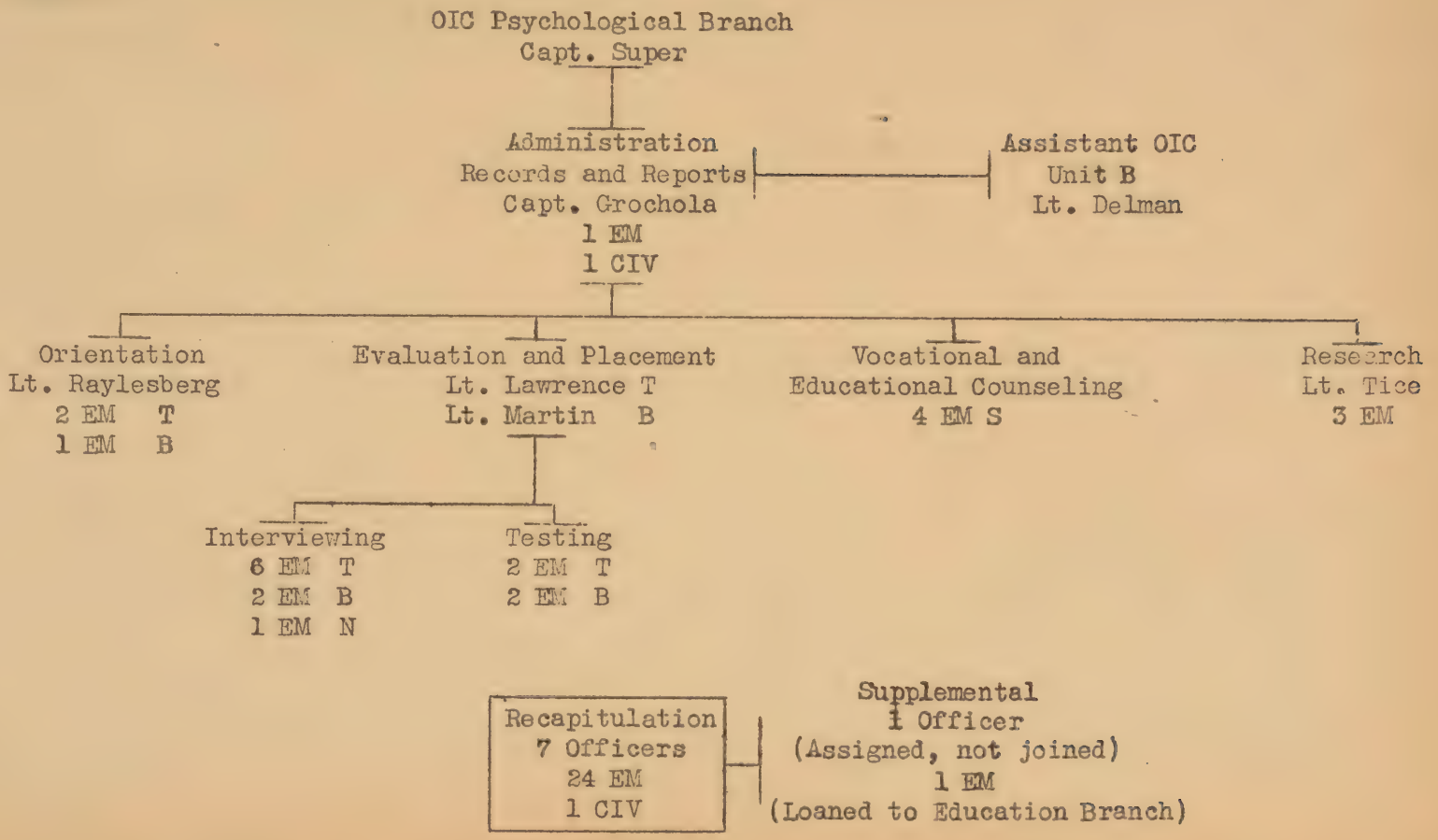


RESTRICTED

T - Tower
B - Biltmore
N - Nautilus
S - Surfside

ORGANIZATION CHART
TABLE VIII

30 June, 1945



Pfc Greene Cpl Goheen S/Sgt Newman Pfc Davis

Pfc Harris Pfc Uhlaner Sgt Miller Sgt Burnett T/Sgt Levine Pfc Morton Pfc Neuman Pfc Howard

Lt Raylesburg Lt Lawrence Lt Martin Miss Regenstein Capt Super Capt Grochola Lt Tice Lt Delman

Pfc Tierney Cpl Eisenberg S/Sgt Deady Cpl Reiff Pfc Polard Pfc Leskowitz Pfc Billstone Cpl Robinson

SECTION II

PERSONNEL

The military personnel situation of the Psychological Branch has been unlike that in either the Psychological Research Units or Medical and Psychological Examining Units of the AAF Training Command. Like the former, this Branch has had as its mission the performance of a highly professional task, specifically, the diagnosis and counseling of mentally or physically ill soldiers and the improvement and devising of techniques and procedures for this work. Like the latter, it has had to accomplish its mission with a small proportion of highly trained and experienced psychologists. By October 1944, when the Branch was organized, the Aviation Psychology Program included so many activities that it was no longer possible for most officers to be over thirty years of age and to have the Ph.D. degree in Psychology, nor was it possible to assign to the Branch many enlisted psychologists with more than the equivalent of a B.A. in Psychology.

Reference to the roster of Branch personnel will show that all officers assigned to this Branch at the time of writing had degrees in Psychology, of which two were Ph.D.'s with several years of civilian experience in Psychology, two were M.A.'s with considerable work toward the doctor's and with at least three years' civilian experience, two were M.A.'s with little civilian experience but considerable military experience, and one was a B.A. with several years of military psychological experience. Similarly, the enlisted men include two near Ph.D.'s, one of whom had significant civilian experience before entering the Army, eight men with the equivalent of a B.A. degree in Psychology (e.g., three and one-half years of college plus ASTP training in Personnel Psychology), nine men with the equivalent of an M.A. and some experience in Psychology or social work, and five men with less than a college education of whom three are only high school graduates and all of whom were assigned to the Branch from MPEU's in June 1945. These five men are being indoctrinated and tried out to determine whether the least skilled assignments in this Branch can, as in the MPEU's, be performed by non-psychologists. That problems of mental and emotional adjustment are involved rather than the administration of routine tests or the recording of objective test scores as in the MPEU's makes this something of a question, but it is anticipated that Initial Orientation and routine statistical work in the Research Section may be suitable assignments for non-psychological personnel.

Training programs have been carried on to improve the skills and insights of Branch personnel. Some of these have been formal, as in the case of Convalescent Orientation leaders and, currently, Evaluation Interviewers and Counselors; some have been informal, as in the case of Clinical Examiners who have been, and are being, trained in the use of individual intelligence tests for mental diagnosis, in the Rorschach technique, and in the Thematic Apperception Test. The personal libraries

of officers and men, some of them rather complete, and the psychological publications in the technical and medical libraries, have been useful in these training programs.

The unusually attractive and complete facilities, both military and civilian, of the Miami District, have done a great deal to keep up the morale of the personnel of this Branch. Working space, B.O.Q. and barracks, and recreational facilities and messes, have all been very satisfactory. It is only fair to say that only two factors have, in the long run, had a detrimental effect on morale.

One is the difficulty in finding housing for married officers and men and the expense of such housing when found (e.g., one first lieutenant paid $235.00 for his efficiency apartment at the height of the season, and another officer, forced to give up his quarters at the Redistribution Station after being transferred to the hospital, is obliged to pay $137.00 per month for a house available for the summer only).

The other is the perennial problem of promotions. Although the Branch manning table provides for no grades lower than corporal, and only four of these, thirteen enlisted men are privates and privates first class, some of them having been in grade for more than two years despite considerable ability and training. The officers have, except in one case, been more fortunate, but this has been because all but the OIC have come to this station as lieutenants. Enlisted promotions have been blocked because the station as a whole has been over strength in grade. As always, the morale (but not the efficiency) of trained men with considerable native ability and a highly skilled assignment has been somewhat adversely affected by contact with less able and less skilled men who, by virtue of historic accidents, have more rank.

The civilian personnel situation has constituted a more serious handicap to the work of the Branch. Due to the failure of another Branch to include in the manning table prepared in January 1945 a large number of civilian employees already working for it, the hospital as a whole was almost immediately up to its authorized civilian strength. For this reason, it was possible for this Branch to employ only one of the three authorized civilians. Requisitions for the two others have been in for some time, but these cannot be filled until the station manning table approved by the War Manpower Board on its visit in March 1945 is approved in Washington. The result has been a delay in the typing of everything but weekly and monthly reports, the typing of many reports, letters, forms, and tests by officers and enlisted men, and the indefinite shelving of a number of projects, e.g., the preparation of an Activity Preference List which no typist has had time to type. The one civilian stenographer on duty with this Branch has, in truth, done "yeoman service". The Branch at Unit B has had to rely on the personnel of the Convalescent Services Division for clerical help. A civilian (CAF-3) at Unit S, who had been assigned to work in the Vocational and Educational Counseling Section of

the Branch, was transferred to the Personal Affairs Branch at the time the Separation Service became a Personal Affairs responsibility. Additional civilians have been requested repeatedly, but because of station manning tables not being finally approved, the Branch has been unable to procure them.

At the time of the activation of this Branch, the personnel consisted of three officers and two enlisted men. Because of the specialized nature of work to be accomplished, the Branch was unable to procure personnel locally and was entirely dependent upon Headquarters, AAFPDC, to fill its Table of Organization.

The first manning table of this Branch, submitted 27 November 1944, called for seven officers, twenty enlisted men, and six civilians. The required strength changed from time to time due to changes in the organization of the Branch and various activities contemplated or begun at other hospital units. Since that time, units have been established at Units B, S, and N at various distances from the original unit at the Tower Hospital, the Biltmore Unit being 17 miles and the Nautilus and Surfside Units being three miles each.

A revised manning table submitted 18 February called for a total of eight officers, twenty-two enlisted men, and four civilians. The Branch, although under strength until late June, has been operating under this manning table pending approval from Headquarters, AAFPDC.

At the present time, the Branch consists of seven officers, twenty-five enlisted men, and one civilian, with one additional officer assigned but not joined. Names, grades, and professional qualifications of all officers and men follow.

PERSONNEL ASSIGNED AS OF 30 JUNE 1945

Name	Rank	ASN	Period of Service (months)	Professional Qualifications	Duty
Super, Donald E.	Captain	0900989	6	Ph.D.,Psychology,Columbia University; Associate Professor (on leave),Teachers College,Columbia University; Director,Cleveland Guidance Service, 1 year; Associate Professor of Psychology and Director, Student Personnel Bureau, Clark University, 4 years; Lecturer in Guidance, Harvard University, 1 year. Author of two texts.	Branch OIC
Grochola, Chester W.	Captain	0577769	8½	A.B.,Psychology,University of North Carolina	Ass't Branch OIC
Raylesberg, Daniel D.	1st Lt.	0588604	9	M.S.,Psychology, C.C.N.Y. Occupational Analyst, USES Washington, D.C., 1 year; Social Welfare Worker, Social Security Board, 1 year	OIC, Orientation
Delman, Louis A.	2nd Lt.	0928531	5	M.S.,Psychology, Univ.of Virginia, 2 yrs. graduate work at NYU; Psychologist, New York State Dept. of Correction, 1 year; Psychologist, N.Y. City Dept. of Correction, 2 years; Occupational Analyst USES, 1 year.	Ass't OIC, Unit B

Name	Rank	ASN	Period of Service (months)	Professional Qualifications	Duty
Hemphill, John K.	2nd Lt.	0931889	Asg'd, not jd.	B.A.,Psychology, Ft. Hays State College, Kansas. Graduate work at Clark Univ.	
Lawrence, Douglas H.	2nd Lt.	0928823	4	M.S.,Psychology,Univ. of Washington, Teaching Fellowship, Psychology, Univ. of Washington, 1 year.	OIC,Evaluation & Program Placement
Martin, Leslie L.	2nd Lt.	0931304	½	M.S.,Psychology,Purdue Univ; Dir., Psych. Clinic Public Schools, Michigan City, Ind., 4 yrs; high school instr. 1 yr; student instr., Purdue Univ. Speech and Hearing Clinic, Industrial Psychologist, Ft. Wayne, Indiana, 1 year; Director OCD, Michigan City, Ind., 1 year.	OIC, Evaluation & Program Placement, Unit B
Tice, Frederick G.	2nd Lt.	0929782	4	Ph.D.,Psychology,Univ.of Virginia, Instructor in Psychology, Hollins College, 1 year	OIC, Research Section
Levine, Abraham S.	T/Sgt.	17066735	7½	B.A.,Psychology, Univ. of Iowa; 1 yr. grad. work in Psychology, Univ. of Iowa	NCOIC, Research
Deady, Robert L.	S/Sgt.	31127102	7½	Ph.B., St. Michaels College; B.S. in Education, Mass. State Teachers College; ½ year grad work in Education, Mass. State Teachers College. Algebra teacher in Chicopee, Mass., 6 years.	NCOIC, Administration and Personnel

Name	Rank	ASN	Period of Service (months)	Professional Qualifications	Duty
Newman, Emanuel	S/Sgt.	39258354	1	B.A.,Psychology, UCLA; 1 year grad U.S.C.; Psychological case worker, California State Dept of Institutions.	Eval.& Prog. Plac. Intvr. NP Wards, Unit B
West, William A.	S/Sgt.	39o07547	6	B.A. Montana State, High School Principal 2 years, Medicine Lake, Montana.	Detailed to Educ. Branch
Burnett, Robert L.	Sgt.	36717107	7½	3½ yrs. Psychology, Univ. of Illinois, ASTP Personnel Psychology. Probation Officer, Juvenile Court, Winnebago County, Ill. 1 year.	Receiving Interviewer Unit T
Miller, Samuel L.	Sgt.	31389867	7½	M.S. Social Service,Harvard Univ. Recreational, Educational Director, Burroughs Foundation, Friends of Young Judea, 4 years.	Evaluation & Program Placement Intvr. Unit T
Balistrere, Frank	Cpl.	13022416	½	High School Graduate; 18 months, Group & Psychomotor Testing MPEU 9	Research Assistant
Eisenberg, Arthur	Cpl.	32610518	7½	M.A., Psychology,NYU; Child Supervisor, Hebrew National Orphan Home, Yonkers,N.Y., 1 year.	Clinical Examiner, Unit B
Gohoen, Howard	Cpl.	13074617	7½	1 year George Washington Univ., 3½ years Muhlenberg College, ASTP in Personnel Psychology.	NCOIC, Orientation Unit T
Reiff, Harry M.	Cpl.	12185637	7½	BSS Philosophy, C.C.N.Y.	Evaluation Testing, Unit T

Name	Rank	ASN	Period of Service (months)	Professional Qualifications	Duty
Robinson, Richard G.	Cpl.	32691150	7½	B.S., Psychology, Harvard University	Clinical Examiner, Unit B
Billstone, Laurie	Pfc.	33841733	5	M.A., Social Work, Univ. of Pittsburg; Social Worker and Supervisor, American Red Cross, 4 years	Orientation Lecturer, Eval. & Prog. Plac. Intvr. Unit B
Davis, Stanley R.	Pfc.	32960558	½	2 years Univ. of Alabama, Personnel Manager, 1 year	Eval.& Prog. Plac. Intvr. Unit T
Diment, Veldon J.	Pfc.	39323574	7	B.A. Social Science, Pacific College; ASTP, Personnel Psychology.	Eval.& Prog. Placement Interviewer, Unit N
Feldman, Robert	Pfc.	32988743	8	B.S.S. in Sociology CCNY; 1 year grad. work, N.Y. School for Social Workers. Social Worker, NY City Dept of Welfare, 3 years. Counselor, Bd. of Education, N.Y. City.	Eval. & Prog. Placement Interviewer Unit T
Greene, Samuel	Pfc.	32903019	9	B.S. Psychology, Long Island Univ.; ½ yr. grad work Psychology, N.Y.U. Social Worker, Willoughby Settlement House, NYC, 2 years.	Evaluation Testing Unit T
Harris, David	Pfc.	32784593	7½	2½ years Accounting, NYU; ASTP Personnel Psychology.	Eval.& Prog. Plac.Intvr. Unit B

Name	Rank	ASN	Period of Service (months)	Professional Qualifications	Duty
Howard, Herbert S.	Pfc.	42034867	½	2 years NYU. MPEU #6	Vocat. & Educat. Counselor,Unit S
Leskowitz, Edward A.	Pfc.	12086114	7	B.B.A.,Accounting,St.Johns Univ.; ASTP, Personnel Psychology	Eval. & Prog. Plac.Intvr.Unit B
Morton, Bert	Pfc.	12090708	7	A.B.,Political Science,Brooklyn College; ASTP, Personnel Psych.	Research Ass't.
Neuman, Gerard G.	Pfc.	36633583	7½	M.A. Psychiatric Social Work,Ohio State. Psychiatric Social & Guidance Worker, 1 yr.,Bureau of United Charities,Chicago,Ill. Clinical Psychologist,Institute for Juvenile Research, 1 yr.,Columbus, Ohio	Vocat. & Educat. Counselor,Unit S
Polard, Robert J.	Pfc.	12177567	½	1 year Fordham Univ.,14 months interview clerk, MPEU 6, 4 months.Personnel Consultant's Ass't, Station Hosp., Keesler Field, Miss.	Orientation Lecturer; Eval. & Prog.Plac. Intvr.,Unit T
Siegel, Saul M.	Pfc.	33747260	Assgd. 30 June	B.A. Social Science, Univ. of Chicago.	Eval. & Prog. Plac.Intvr,Unit T
Tierney, Thomas E.	Pfc.	42037675	7	M.A. Psychology,St. Johns Univ.; Vocational & Educational Counselor, Power Memorial Academy, 1 year.	Vocat.& Educat. Examiner,Unit S
Uhlaner, Julius E.	Pfc.	33750676	7½	M.S. Psychology, Iowa State;Industrial Psychologist,ODT,Wash.,D.C., 2 yrs; Industrial Psychologist,Ford Motor Co., 1 year; Research Associate, NYU, 1 year	Vocat. & Educat. Counselor & Examiner,Unit S

PERSONNEL TRANSFERRED FROM BRANCH

Name	Rank	ASN	Date Assigned	Date Departed	Qualifications	Duty
Strongin, Edward I.	Major	0509329	2 Oct 44	6 Jan 45	Ph.D.,Cornell U.; Research Associate, Columbia U. School of Medicine,7 yrs.	Branch OIC
Darlington, Meredith W.	2nd Lt.	0588770	30 Sep 44	19 Apr 45	Ph.D, Univ. of Nebraska; Asst Prof. of Ed.,Okla A&M, 1 yr; Instr. in education, Univ. of Neb.,5 yrs.; Ed. & Vocat.Consultant,3 yrs.; Princ. & Tchr., Jr. H.S., Fairbury, Neb., 6 yrs.	OIC,Vocational & Educational Counseling Sect. Unit S
Rotter, Julian B.	2nd Lt.	01019401	14 Apr 45	28 Apr 45	Ph.D.,Psychology, Indiana U.; Psychologist,Worcester State Hosp., 1 yr; Norwich State Hosp., 1 yr; Indiana U., 1 yr.	Testing
Atwood, John Thomas	2nd Lt.	0930836	12 Feb 45	28 Feb 45	B.S.,Psychology, U. of Wisc.; 1 yr. grad work, Columbia U.; Psychologist, NY State Dept. of Correction, 9 years.	Attached for training
Christopher, Wilford S.	S/Sgt.	18094209	20 Oct 44	23 Apr 45	M.A.,Sociology, U.of Iowa; Asst. Prof.,Sociology, Phillips U., 4 yrs; Personnel Consultant, Phillips Univ., 4 yrs.	NCOIC,Vocat. & Educat. Counseling Unit S

Name	Rank	ASN	Date Assigned	Date Departed	Qualifications	Duty
Bradley, Arthur	Cpl.	39311549	17 Nov 44	8 Jan 45	M.A., Psychology, U. of Minn.	Eval. & Prog. Plac. Intvr., Unit T
Calculator, John P.	Pfc.	32816860	1 Nov 44	29 Mar 45	1 year, Business Adm., Pace Institute	Administration
Cohen, Moses H.	Pfc.	32628686	17 Nov 44	22 Dec 44	B.A., Psychology, Brooklyn College.	Eval.& Prog. Plac. Intvr. Unit T
Ferguson, Charles K.	Pvt.	39576749	17 Nov 44	8 Jan 45	M.A., Education, UCLA	Eval. & Prog. Plac. Intvr., Unit T
Ward, Leo C.	Pvt.	14059118	17 Nov 44	8 Jan 45	2 yrs. pre-med., George Washington U.	Eval. & Prog. Plac. Intvr. Unit T

SECTION III

PROCESSING AND SERVICE

The psychological program in convalescent hospitals being relatively new, officers and men in other branches have had many different ideas as to the nature and functions of the Psychological Branch. Convalescent training officers have thought in terms of orientation to the hospital and to the convalescent program, of publicity for convalescent activities, of placement in the program, and of work with chronic absentees. Scheduling personnel have been aware of the program placement function but have only slowly come to realize that such work, as done by psychologically trained personnel, is more than merely scheduling a man for courses. Medical personnel have, in some cases, tended to regard the Branch as a would-be intruder into their field of treatment or psychotherapy, while others have been aware of the possibilities of diagnostic testing and have tended to minimize other functions.

Relatively few outside of the Branch itself have seemed to understand the variety of psychological services which might be rendered by an organization such as this, even though these are pointed out in directives. For this reason, considerable time and effort have been given to the informal education of officers and men in other services and branches by means of talks at staff meetings, discussion of specific patients in the coordination of work with medical officers and instructors, and casual conversations. It has been equally necessary to keep Branch personnel aware of the varied objectives of the Branch and alert for opportunities to provide appropriate services.

An attempt has been made to have Branch personnel note incidents and data illustrating the various services of the Branch and to circulate these among permanent party personnel in order to develop a concrete understanding of their purposes and nature.

As outlined in directives, the processing and service activities of the Branch are as follows:

1. Initial Orientation (to the hospital and convalescent program);
2. Evaluation and Program Placement (initial, supplementary, terminal);
3. Continuous Orientation (to convalescence and return to duty);
4. Special Diagnostic Testing (on referral);
5. Counseling.

What these are and how they have developed is the subject of the following pages.

PROGRAM PLACEMENT AND EVALUATION INTERVIEW

CONTINUOUS ORIENTATION (PHASE III)

CONVALESCENT ORIENTATION

The Orientation Section of this Branch began to function almost immediately upon activation of the Branch at Unit T. With a small staff, an only partially developed program, and lack of space, the work was nevertheless inaugurated on 9 October 1944 in the basement of the Gulfstream Hotel. Pending receipt of authority in the form of written directives, a program of initial orientation was carried on in connection with processing which gave over an hour to a talk designed to acquaint incoming patients with what the hospital was doing, the activities of the Convalescent Services Division, and the functions of the Branch. A series of twelve lectures covering the field of mental hygiene and applied psychology as it might affect patients in this hospital and military personnel in general was also worked out for continuous orientation, but because of limited space it was necessary for the first two months to condense these lectures into a five-hour course with patient attendance required.

During this formative period, three significant events aided in removing most of the initial difficulties and cleared the way for more intensive development of the mission of the section. They were, in their chronological sequence, as follows:

Authority for operating, in the form of AFPDC Ltr 80-56, dated 3 November 1944, which provided for a three-phase orientation program;

A move from the Gulfstream basement into Cottage #5 on 18 November, greatly enlarging the working space and furnishing rooms for the increased duties of this section. Two weeks later the Section moved into permanent quarters on the second floor of Cottage #7;

The enlargement of the Branch's staff by the arrival in mid-November, 1944, of additional enlisted men.

Initial Orientation, Phase I and II

Paragraph 3c of AFPDC Ltr 80-56, 3 November 1944, provides for "orientation....in which the Convalescent Hospital Program is described and explained and an effort made to secure the patient's cooperation and interest." This was known as Phase One, Orientation. Phase Two, Orientation, is provided for in paragraph 3f(2) as follows: "....orientation which will outline and describe the facilities of the Convalescent Services Division, the aims and purposes of the program, and what is expected and desired of the patient."

Patients assigned to Unit T are first admitted to the hospital at Unit P. In order to offer Phase I, Orientation, it would therefore be necessary to operate at Unit P. The distance involved and lack of

transportation and personnel made this impossible; in the interests of efficiency, it was decided to combine the mission of these two phases into one comprehensive lecture to be given at the beginning of the day's processing at Unit T, N, or B.

The outline of this lecture was coordinated with all other branches of the Division. Investigation of other departments and cooperation with them were imperative if the men charged with the task of orientation were to do the job adequately. Heads of branches and sections, enlisted men doing the individual tasks which were to affect the patients, and civilian personnel engaged in activities of interest to patients (American Red Cross, Mail Desk, etc.), were all consulted and aided in the development of the initial orientation procedure.

As a result, an outline was prepared which was to become the guide for future sessions and the basis for the modifications which were to come as a result of an ever-changing and expanding hospital program. The original outline follows:

* * *

Initial Orientation Outline I, Unit T
4 December 1944 to 17 January 1945

Initial Orientation Lecture
Phase I and II

I. General

A. You are here for a brief period of convalescence before return to duty or other disposition, as recommended. You are here because medical officers have determined that you should have the opportunity for convalescence and reconditioning in surroundings and under conditions most conducive to speedy recovery.

B. According to policy adopted by the AAF Convalescent Hospital early in the war, it has been decided that a minimum of time is needed to return men to duty and health if the patient's time is taken up with a constructive program of occupational therapy and physical exercise. Toward this end, AFPDC Regulations state that a patient shall engage in five hours of activity a day for five days each week.

II. Physical Set-Up of the Hospital

A. The Miami Beach Convalescent Hospital is divided into three sections: the Pancoast Hospital, which handles medical cases; the Nautilus Hospital, which handles surgical cases; and the Tower Hospital, which handles operational fatigue cases, and is charged with handling the bulk of the convalescents from all three units. The Tower Unit

consists of two hotels, the Tower and the Gulfstream, and nine cottages adjacent to the Gulfstream Hotel.

B. Even though this is a hospital, it is nonetheless a military installation, and you may find that the standards are not as relaxed as you may have come to expect. You are a patient and medical considerations are paramount. However, military requirements are to be expected and complied with. Attendance is required during the five hours of scheduled activity per day, and the post regulations are enforced.

C. If you are married and have your wife here, you are allowed an overnight pass from 5 p.m. until 8 a.m. If you are single, or your wife is not here, passes are issued from 5 p.m. until 12 midnight. On week-ends, married men may draw passes from 1 p.m. Saturday until 8 a.m. Monday. Other passes are valid until 2 a.m. Sunday. Passes will not be issued unless they are requested and picked up before 5 p.m. on week-days, or 1 p.m. on Saturday.

III. Individual Treatment

A. Although this is an Army hospital, you will find slight deviations. For the first time, perhaps, the Army is making a serious attempt to treat you as an individual rather than as a serial number. It is recognized that, given a pleasant environment and an opportunity for constructive and interesting work, a man will return to full health much sooner than would otherwise be the case. To that end, we are attempting to make your physical surroundings as pleasant as possible, and to make your scheduled activities as voluntary as we can, with consideration for medical requirements. You have a personal physician to whom you can take your medical problems, and you are also afforded the opportunity to receive individual counseling in the Psychological Branch for any non-medical problems.

IV. The Educational Program

A. Of the five hours of activity for which you will be scheduled, three hours per day will be in activities under the supervision of the Educational Branch. These hours will be occupied with elected activities of a vocational or academic nature.

B. (Enumerate and describe educational courses offered).

C. (Enumerate and describe vocational activities offered).

D. (Enumerate and describe avocational activities offered).

E. Arrangements can also be made to take courses toward high school or college graduation credits through the Armed Forces Institute. (Explain).

V. Physical Reconditioning

A. Of the five hours of activity for which you will be scheduled, two hours per day will be taken up with activity under the guidance of the Physical Reconditioning Branch. These activities will take into consideration your physical condition and will be individualized accordingly.

B. Certain activities, such as tennis, golf, and fishing may be substituted for the physical reconditioning period. In addition to the prescribed instruction, we urge you to participate in as many of the physical activities as we have available. (Describe local facilities).

C. (Describe procedure for engaging in such activity as golf, tennis, fishing, etc.).

VI. The Psychological Branch

A. This Branch, in addition to delivering this introductory talk, offers an orientation series of lectures in psychology to aid you in personal adjustment and a practical approach to the understanding of personal problems and everyday living.

B. (Explain and describe individual counseling and guidance facilities).

C. (Explain and describe function and purpose of initial and terminal interviews).

D. (Explain and describe hospital program placement and recommendation for duty assignment).

VII. Special Services

A. The Special Services Branch serves essentially the same purpose here as at any other military installation. Because of the importance of varied and extensive recreational activity, this Branch has a somewhat broader function here. A weekly mimeographed bulletin will be found in the lobby of the Tower and Gulfstream Hotels, listing the functions taking place daily.

B. (Enumerate and describe various local functions).

VIII. Other Activities

A. American Red Cross (describe and explain).

B. Personal Affairs Office (describe and explain).

C. Legal Assistance Officer (explain and locate).

D. Chaplains (explain and locate).

* * *

This program was inaugurated on 4 December 1944 and the original outline continued in effect until 18 January 1945 when the first revision was initiated, the result of increased facilities of the Convalescent Services Division. Late in February the film, Out of Bed Into Action, became available, and on 1 March 1945 the showing of the film was incorporated as a part of the initial orientation program to present the Convalescent Program to the patients in an interesting and novel way.

* * *

Initial Orientation Outline II
18 January 1945 to 23 April 1945

Initial Orientation
Phase I
(Given by Officer)

I. Welcome to the Convalescent Hospital.

II. Explain organization and development of PDC:

A. ORD, Redistribution Stations, Convalescent Hospitals (name these and others).

B. Names of Commanding General and PDC Surgeon.

III. Trace development of Convalescent Training Program:

A. Reasons for establishment (describe old system - men came out of station hospitals in poorer condition physically than when they went in. Show rate of improvement under new program).

B. Col. Rusk's contribution.

C. Trace development from station hospital to present Convalescent Hospitals.

IV. Explain theory underlying program:

A. Stress treatment of patient as an individual.

B. Use of planned purposeful activity:

(1) PDC requires 5 hours of activity per day, 5 days per week.

C. Proof of value of program:

1 Therapeutic value - as an aid to speedy recovery.

2 Keeps men from becoming bored, getting soft, losing skills.

V. Organization set-up of Miami Hospital:

A. Merger with Regional Hospital at Coral Gables:

1 Name and location - Biltmore, Pancoast, Nautilus, Tower-Gulfstream

B. Give names of CO, Executive Officer, Director of Convalescent Services, Adjutant, and heads of branches of Convalescent Services Division.

VI. Mention Personal Physician system:

A. Show the patient that he will have a physician permanently assigned to his case while he is here, and that the physician is available for discussion of patient's medical problems.

VII. Mention Program Placement function of Psychological Branch:

A. Show availability of interviewers and counselors for program placement, adjustment and readjustment of program difficulties, and non-medical problems.

VIII. Military Requirements:

A. Although this is a hospital, it is still a military installation and military requirements must be complied with.

B. Stress regular attendance at scheduled activities:

1 Two hours daily in physical reconditioning

2 Three hours daily in other activities

C. Explain pass regulations:

1 Married men - 1700 to 0800 weekdays; 1200 Saturday to 0800 Monday.

2 Single men - 1700 to midnight weekdays; 1200 Saturday to 0200 Sunday; 1100 Sunday to 2400 Sunday.

IX. Turn group over to enlisted man for Phase II of Orientation.

Phase II
(Given by Enlisted Man)

I. Show AFPDC film, Out of Bed Into Action.

II. Distribute pamphlet on hospital activities.

III. Show physical set-up of this hospital:

A. Tower - locate. Houses PX, mail room, activities bulletin board.

B. Gulfstream - locate. Houses administrative offices, ARC, Special Services, barber shop, cleaning and laundry, PT office, Plans & Schedules, Physiotherapy, Dental Clinic, pass control desk, admission office, pro station.

C. Cottages - locate. #1 - Training Aids Theatre; #2 - Radio and Academic Classrooms; #3 - Arts & Crafts; #4 - Academic Classrooms; #6 - Nurses Quarters; #5 and #9 - not used by hospital; #7 and #8 - Program Placement & Psychological Branch.

D. Woodworking and metal working shops - locate.

E. Mess hall - locate

IV. Explain physical reconditioning program.

A. 2 of the 5 hours of daily activity under the guidance of this Branch.

B. Individual activity - patient's physical condition taken into consideration.

C. Other activities along these lines - describe procedure for engaging in:

(1) deep sea fishing, golf, tennis, bicycling, etc.

V. Explain educational program:

A. 3 hours of daily activity under the guidance of this Branch.

B. Stress individualized activity - every effort will be made to put men into the academic and avocational activities which they themselves select. Show advisability of stating more than one choice to interviewer.

C. Briefly state variety of subjects and activities offered.

D. Show possibility of changing program by consulting the Psychological Branch.

E. Explain possibility of taking courses through the USAFI toward high school and college credit. Explain method of applying.

VI. Explain function of Psychological Branch:

A. To assist in any problems other than those of a medical nature.

B. Show the nature of, and required attendance at, convalescent orientation course twice weekly:

1 A practical approach to the understanding of human nature and behavior; why we are what we are; why others behave as they do; so that we can better understand ourselves and others.

VII. Explain functions of Special Services Office:

A. Weekly activity bulletin - describe and locate

B. Describe activities - dances, personal appearances, free tickets to sporting events, concerts, movies, restaurants, golf, etc.

VIII. Explain function of and locate other offices:

A. American Red Cross

B. Personal Affairs Office

C. Legal Assistance Office

D. Chaplains' Offices:

1 Catholic and Protestant - services at Nautilus - transportation

2 Jewish - YMHA on Friday nights; Jewish Community Center at 14th and Euclid Avenue.

IX. Transportation:

A. GI bus leaves here every hour on the half hour for the Pancoast, via the Nautilus.

X. Describe recreational facilities on Miami Beach:

A. War Department Theater, 31st and Collins

B. Elks' Club Saturday night dances (alternate weeks for Officers and EM) 7th and West

C. Miami Beach EM Recreational Center, 21st & Washington

D. NCO Club, 49th and Collins

E. Officers Club, Nautilus BOQ

F. YMHA, Lincoln & Collins

G. Lutheran Service Men's Center, Lincoln & Collins

H. Servicemen's Pier, 1st & Collins

I. 41st St. Theatre

J. Jewish Community Center, 14th & Euclid

XI. Ask for any questions concerning the program, the hospital, etc.

XII. Distribute appointment slips for initial interview.

* * *

The next and last revision in the procedure of the Section was the most complete. Initial orientation was planned to include a tour of the Convalescent Services Division facilities. Since the last revision, the hospital activities had greatly expanded. The variety of activities offered the patients made it virtually impossible to give the complete picture verbally. Preparations were made to include a tour of the hospital grounds and on 23 April 1945 initial orientation was revised to do this.

At the same time, the Chief of the Convalescent Services Division agreedto welcome the patients personally on their assignment to the Convalescent Hospital, and on the same date the first part of initial orientation was turned over to him. These changes increased the time devoted to initial orientation and necessitated changes in the system of scheduling for processing. Henceforth, the combined talk and tour were to occupy the full morning. The value to the patients was considered to be well worth the additional time spent, and to the present time, this final revision has continued. The complete description of the activities which now make up the initial orientation follows:

* * *

Initial Orientation, Outline III, Unit T
23 April 1945 to date

Time	Activity
0800 - 0900	Prepare upstairs classroom in cottage 7. This will include putting the room in order, setting up the projector and screen for showing the film.
0900 - 0945	I. Introduce Chief, Convalescent Services Division (or OIC, Orientation Section)
	II. Briefly state the day's activities
	A. showing the film, "Out of Bed Into Action"
	B. tour of the facilities
	C. interview in the afternoon in cottage 8
	D. Plans & Schedules Office
	E. married men to cottage 4
	III. Explain the P.T. set-up
	A. individual treatment
	B. physio and corrective exercise
	C. short calesthenics period (not more than 15 minutes)
	D. beach facilities
	E. golf (clubs, balls, greens fee pass, transportation, pro at club, play anytime during PT hour or free time, through Special Services)
	F. deep sea fishing (trips every day except Sunday, transportation at 0830, boats leave 0900, go only once a week, docked at Nautilus, through Plans and Schedules)
	G. dock and pier fishing (tackle and bait transportation furnished, Nautilus or Sunny Isle pier, through Special Services or PT Office)
	H. tennis (racquet and balls furnished through PT office, courts at Nautilus and Pancoast, transportation furnished)
	I. bicycle riding
	IV. Show film, "Out of Bed Into Action"
0945 - 0955	V. Visit downstairs classroom and explain:
	A. educational set-up - classes in physics, algebra,

law, languages, current events, English, flight facts, mathematics, etc.--(keep up to date on this)
stress quality of instruction
illustrate class or two with explanation
(this section does not lend itself as well to demonstration as do the shops and other activities, so you will have to do a better selling job here with what you have to say)

B. explain USAFI

C. explain GED set-up

0955 - 1000 VI. As you go over to the shops explain the functions of cottages 5, 6, 7, 8, and 9.
Cottages 5 and 9 -- visiting officers
Cottage 6 -- nurses quarters
Cottage 7 -- academic classrooms, newspaper, convalescent orientation.
Cottage 8 -- program placement, interviewing, testing

1000 - 1015 VII. Move through the shops in the following order and explain:

A. Plastics shop (show examples of work done, machinery used, instruction and material furnished).

B. Woodworking shop (show first examples of the smaller work in the wood carving section, then move out and show machinery in the larger part of the shop. Stress that the only limitation will be the ability of the patient. For the beginner, expert instruction is furnished.

C. Art metal section (show examples of work done and machinery used).

D. Leathercraft section (show exhibits if available; if not, cite projects, i.e., billfolds, key cases, picture frames, etc.).

E. Machine shop (stress importance of 'know how' if patient is interested in constructing things, stress value of machinery to show that it is not a hobby shop, point out the availability of

instruction for those who wish to learn machine shop practice, operation, maintenance, etc.).

1015 - 1045 VIII. Get into truck which will be waiting outside the shop and proceed to the 68th street shop where you will explain the following:

A. Print shop (show examples of work done by the patients, explain that the shop is equipped to do letter-press, photo lithography, offset printing, blueprinting; show what can be done and show the equipment available).

B. Link trainer (show the equipment and explain the opportunity for getting instrument time on the Link if desired).

C. Radio shop (move over to the repair section and explain that both radio repair and radio building are available in classes).

D. Auto shop (show autos in process of repair, explain class only for those patients with own car, show all the facilities available, explain discount offered on new parts, show that work will not be done by the instructors, their function being to show the patient how and to assist him).

E. Photography shop (show all equipment, explain available instruction in development, printing, enlarging, flash photography, etc., point out camera library with 616 box type and movie cameras for loan purposes, show 35 mm and speed graphlex for instructional purposes).

F. Photo-tinting (show samples, point out that the photographs will be furnished or that the patient may supply his own).

After this, go back to truck which will be waiting, and return to hospital at Cottage 1.

1045 - 1110 IX. Go through the area of cottages 1 through 4 and Gulfstream basement, explaining:

A. Cottage 1 (training aids)

B. Cottage 2 (arts & crafts and home planning)

1. painting (show exhibits of work, point out that both skilled and beginners have been enrolled in the classes, show that pencil, charcoal, water-color, pastel, and oils are all taught plus work in cartooning and other special fields).

2. sculpture (show exhibits of work and beginning work).

3. sketching & cartooning (show exhibits of work, mention visits of professional cartoonists and models. Work done in pencil, pastels, charcoals, inks).

4. home planning and drafting (show samples of work, explain that complete plans for the post-war home may be drawn here, expert instruction, blueprinting service, scale model construction of finished work, cost estimation, and budget home planning).

C. Cottage 3 (music, dramatics, and radio)

1. music appreciation (show music room, explain function of music appreciation class, and while there, explain).

2. music theory (class in how music is written and how to write music).

3. piano instruction (show instruction rooms, mention also availability of clarinet, sax, violin, trumpet, etc. for practice purposes).

4. dramatics (point out model stage and show facilities for instruction in script writing, stage management, production, make-up, etc.).

5. radio (show mirror-phone and explain its usefulness in instruction for radio announcing, production, acting, etc.; mention instruction in radio script writing).

D. Cottage 4 (point out that this cottage is for the use of the wives of the patients, dressing rooms, lockers, facilities for babies, crib, play pen, cooking facilities, entertainment

for the wives, lounge for leisure time. Emphasize here that the married men will report back to this cottage after having completed processing at Plans and Schedules in the afternoon. At this point, be sure to explain that the wives of the patients are allowed in the program to the same extent that the patient himself is; she may participate in any or all of the activities that he chooses).

E. Gulfstream basement

1. physio and corrective exercise room (show the equipment and briefly explain the set-up; this may be cut if there are no orthopedics on the tour).

2. point out barber shop

3. skeet and small arms -- show that firing on the range is not only a function of the skeet classes but also of the small arms classes; available weapons: pistol, rifle, Thompson sub-machine gun, shotgun, 30 and 50 cal., etc.).

4. point out pro station

5. point out laundry and dry cleaning

1110 - 1120 X. Move through the area of the Band Shell, beach behind the Tower, Garden of Eden, and Tower lobby:

A. Band Shell (take this opportunity to explain the functions of Special Services, i.e., movie tickets, meal tickets, trips to races, boxing, wrestling, shows, operas, sporting events, plays, dances, golf, fishing, Tower shows, etc.; explain also the NCO club and the Officers' Club).

B. Beach (point out the facilities for recreation and PT, show the bicycle shop).

C. PX and Garden of Eden (give PX information and information on dances held in Garden of Eden.)

D. Mess Hall (give the hours as you pass and procedure for dining with guests).

E. Enter Tower lobby from the front and point out; ARC, mail desk, hours for mail pick-up, activities bulletin board, and dispensary.

1120 - 1130 XI. Return to Gulfstream and on first floor show:

A. Plans and Schedules Office

B. PT Office

C. Dental Clinic

D. Pass Control Desk (give pass hours and times for picking up same).

E. Special Services Office

F. Administrative Offices

G. Go upstairs to the Library (show the Library and then go into the Bookbinding Section and explain classes in bookbinding; show samples of work and point out the machinery and equipment).

1130 XII. Return to the lobby, pick up appointment slips at receptionist desk and:

A. answer any questions

B. pass out appointment slips

C. dismiss the men

* * *

Several special projects calculated to aid in part and to raise the level of efficiency of initial orientation are now in various stages of completion. Work is being done in cooperation with Training Aids, the Shops, and the Photographic Section to prepare for future use a series of slides of hospital facilities in full color for showing to patients in inclement weather when tours of the facilities are not possible. The slides will also be viewed by orthopedic patients who cannot make the tour easily. Another project is that of recording speeches made by prominent people dealing with some aspects of convalescence such as the talk by General Arnold at Pawling, New York,in January 1945.

As mentioned elsewhere, Initial Orientation at Units N and B follows closely the procedures outlined here, except that it takes place when definitive patients are reported as convalescent.

Continuous Orientation, Phase III

A second and equally important function of this Section is that prescribed by paragraph 3g(4) of AFPDC Ltr 80-56, 3 November 1944. "...will conduct two hours a week, phase three orientation, which will be designed to help foster and develop a healthy outlook concomitant with physical healing."

Lack of personnel and space made it necessary, in the beginning, to interpret the spirit of the regulation liberally,and for the first few weeks of operation the classes were conducted for five consecutive days instead of the prescribed semi-weekly arrangement.

As the personnel of the Branch began to arrive, the staff of the Orientation Section was increased, for by 4 December 1944 the patient load in the hospital was such as to justify holding more classes. With the increased space made available by the move to cottages 7 and 8, it became possible to comply with the directive more completely, and the continuous orientation sessions were given twice a week.

The orientation lectures have three basic aims:

1. to give the returnee an understanding of himself by acquainting himself with the facts of applied psychology and mental hygiene.

2. to develop in the returnee a better frame of mind and higher morale so that he will understand why he can and must remain in the army and return to duty.

3. to aid the returnee in the process of adjustment to the United States, soldiers in the states, civilians, etc.

The technique employed is a series of lectures and discussions on pertinent material in psychology. The material to be presented is in agreement with authoritative sources and is presented on a plane comprehensible to the average serviceman. The stress is always on the experience of the soldier in the army, overseas, and on return to the United States; anecdotes and examples used as illustrative material relate, as far as possible, to experiences familiar to the soldier.

It is assumed that, during the process of lecturing on and discussing psychological principles, the returnee will relate what he hears to his own experiences, bringing some of these into the discussion, and, by analysis, arrive at a better understanding of himself. This should result in increased confidence, heightened morale, and better attitudes in general. Through analysis of the inevitability of certain attitudes, the patient may be brought to understand the basis for many of his dislikes and personal maladjustments.

Careful and widespread use of illustrative examples make it easier for the soldier to absorb the ideas relating to his personal experience. Illustrative examples are drawn from the following four broad areas, and wherever possible, a point is made by referring to all or several of these types of situations:

1. common experience, everyday non-war situations likely to be free from any emotional connotations to the patient.

2. stories about the enemy and ourselves in our conduct of the war.

3. incidents common to the daily experience of soldiers, i.e., training in the army, discipline in the army, recreation, etc.

4. anecdotes of experiences common to the overseas and combat soldier.

Both formal lecture techniques and the discussion method are used in presentation of the material. The staff is given sufficient freedom to enable them to develop the session in an individual manner. The only requirement is that the individual conducting the lecture cover the material as set forth in the currently operating outline. It is recognized that the varying backgrounds and experience of the instructors and the lack of homogeneity of the groups make it impossible to standardize the methods of presentation.

The original outline was subject to revisions and modifications as experience with the particular types of patients developed. Used from 20 November 1944 to 4 January 1945, it follows:

* * *

I. Introduction - What is the purpose of this course? What is psychology? How can it be helpful to you as an individual and as a soldier? What is military psychology? How is psychology useful in warfare?

II. Personality and Behavior - What do we mean when we talk about personality? What factors make people different? How does personality develop? What is a "good" or "bad" personality? What makes a personality a desirable one? What are the different ways in which people behave? When is behavior normal? Can we change personality? How do different personalities adjust to the army, to combat?

III. Learning - How do we learn? How do we develop habits, attitudes, tastes? How are opinions formed? What is meant by conditioning? Does learning stop at a certain age? What are different techniques of learning and studying? How can we change habits and attitudes? What do we mean by re-education?

IV. Motivation and Emotions - What motivates us to behave as we do? How do our emotions develop? How can we control our emotions? What are basic drives and how do they develop? Are we always aware of our drives? What part do the emotions play in military life? How can the emotions be utilized to create better soldiers?

V. Conflicts - What is adjustment? What is the difference between adjustment and maladjustment? How do conflicts develop? How do individuals resolve conflicts? What types of conflicts are there? What are the effects of conflicts? What are the sources and effects of frustration?

VI. Military Psychology - Morale - What creates good individual and group morale in an army? What psychological factors enable men to fight well? What psychological factors can contribute to the defeat of an army? What are defensive and offensive actions regarding morale? Why do men fight? What motives urge men to fight?

VII. Military Psychology-Propaganda Analysis - How is psychology useful in warfare? What is propaganda? How is propaganda employed by us? by the enemy? How are rumors created? How can we tell fact from fancy? How can we determine people's attitudes? Can they be changed by propaganda, by education?

VIII. Individual Differences - What is meant by intelligence? What are aptitudes? How do men differ in abilities, interests, vocational skills, mental traits? How can we attempt to measure these differences?

IX. Vocational Psychology - What are the factors that should go into the selection of a future job? What factors govern assignment to a job in the army? What is the basic principle underlying all classification, and, in particular, army classification?

X & XI. Problems of the Returning Soldier - What psychological problems will confront the returning soldier? Will he have a difficult time readjusting to the civilian point of view? How will he compete in the job market? How will he shift from the authoritarian army to the democracy of civilian life? How will he overcome the restlessness or apathy developed during service? What factors are involved in successful married life? How can the soldier be helped to adjust to separation from loved ones while in the army? What problems will he face when he returns to wife and family after the war or upon return to the states?

XII. Government Provisions for Care of Returned Soldiers - What provisions have been made by the government to care for the returning soldier? What are the features of the "GI Bill of Rights"? What unemployment insurance is available to the soldier? What about Social Security, health insurance, etc? What help will the Veterans Administration and the U.S. Employment Service give him?

The first major revision of the orientation series came one month after the program had been in full operation. A new series of lectures was prepared and adopted for use on 4 January 1945.

These lectures were developed as the result of experience in giving the first series. The original plan called for twelve topics to be covered. Experience revealed that three (Introduction, Vocational Psychology, Government Provisions for the Returning Soldier) were unsatisfactory, and one new topic (Mental Hygiene) was developed and proved a valuable addition to the series.

This new series of lectures was used for fifteen weeks from 4 January 1945 until 19 May 1945 before it was found necessary to make any alterations or revisions. The topics follow.

MOTIVATION AND BEHAVIOR
Lecture I

Objectives:

I. To develop the concept that behavior and personality are the result of the composite influence of many factors in the individual's life experiences.

II. To explain the development of various motives and desires and to indicate that behavior is an effort to satisfy these motives.

III. To demonstrate that behavior patterns, habits, and attitudes develop as the result of a learning process.

Method of Presentation:

I. Factors affecting the development of the individual.

Indicate by means of illustrations the important ways in which the following factors may effect individual personality. Get across the great importance of environmental forces in developing and altering behavior and personality. This section should not be too lengthy; it is a general introduction to indicate the variety of forces acting on an individual.

A. Physical factors

1. Hereditary - body size, brain, endocrines, etc.
2. Environmental - illness, injury, etc.

B. Social and environmental

1. Early childhood and family
2. School and friends

3. Community influences
4. Adult experiences - army, civilian life, etc.

II. The development of motives, needs, and desires.

A. There are certain basic physical needs we all satisfy in different ways:

1. Hunger
2. Thirst
3. Sex
4. Avoidance of cold, heat, etc.

B. As the individual matures and comes into contact with other people, he acquires other motives and desires through learning. Explain in a general way how the following important social motives develop:

1. Motive for mastery and desire to feel important
2. Desire for affection and companionship
3. Desire for belonging - to be part of a group
4. Desire for attention
5. Desire for security - explain how behavior may result from insecurity
6. Other desires varying with the cultural pattern such as the desire to make money, to have a good job, to excel at certain sports

C. Much of our behavior can be understood in terms of an effort by the individual to satisfy one or more of these needs, desires, or motives. Explain by citing examples of behavior interpreted in terms of this principle.

III. Patterns of behavior.

A. Behavior patterns develop through learning.

1. We tend to continue those patterns which lead to satisfaction and tension reduction.
2. We behave in novel situations in manners which we have found useful before. A situation completely novel (combat, meeting a bear in the woods) may result in disorganized behavior unless we have developed a well organized pattern for acting in novel situations (confidence, attacking problems, etc.).
3. Explain how a pattern of behavior such as withdrawal may develop as the result of a variety of experiences at home, in school, etc.

4. Explain how a pattern of behavior such as approach to new things may develop as the result of a variety of experiences at home, etc.

B. Common mechanisms of behavior (explain with anecdotes).

1. Compensation
2. Rationalization
3. Projection
4. Displacement
5. Phantasy
6. Identification

(Indicate that each of these mechanisms at times serves a useful function in satisfying the individual's ego and motives, but that if carried to extremes may be unsatisfactory behavior).

IV. The formation of habits.

A. Habits and attitudes are learned.

1. Illustrate with Pavlov's experiment and with other instances of conditioning.
2. Explain how the Nazis have demonstrated that training can form habits and attitudes.

B. Habits can be unlearned.

1. Refer to Pavlov's experiment and explain experimental extinction.

2. Habits can be changed, but the older we are, the more fixed we become in our patterns. But new habits can be learned and old ones discarded with proper technique.

V. Implications of this lecture.

A. To understand our behavior or someone else's behavior, we must analyze what causes him to do things a certain way. Behavior may not always have an obvious reason (e.g., man yelling at wife because he was irritated during the day by boss, etc.). We must find out why particular individuals learned to be set in ways that seem satisfactory or unsatisfactory.

B. The democratic approach of respecting each man's individuality has a sound basis in psychology. Every man is a distinct personality and there are wide differences between individuals. It is unsound to generalize about people belonging to particular racial or religious or any type of group.

LEARNING
Lecture 2

Objectives:

I. To demonstrate the importance of learning and conditioning in man's development.

II. To explain the principles of the learning process, with particular reference to the retention and acquisition of vocational skills and further educational study by the returnee.

Method of Presentation:

I. Learning in relation to individual development.

A. All acts above the reflex level are modified by learning (e.g., the knee jerk reflex unlearned, other motor acts learned).

B. Personality development and behavior depend upon learned habits and attitudes.

C. Learning principles basic to acquisition of motor skills, personality, emotions, learning school subjects, learning vocational skills, etc.

1. Explain conditioning and association as proof by relating experiments of Pavlov and Watson.

II. Nature of the learning process.

A. Trial and error learning.

B. Learning through insight (seeing the "whole" pattern).

C. Learning through association (conditioning). Explain conditioning as conditioning of a response to a total stimulus situation.

D. Problem solving learning in terms of the integration of ideas and the development of insight.

III. Features of the learning process.

A. The nature of the learning curve - describe rapid initial learning, slowing down, and finally decreasing returns in learning.

B. Plateaus and their significance.

1. Reasons for plateaus

   a. mechanization of the lower order of habits takes time
   b. often due to relaxation in interest and effort
   c. sometimes caused by change in method of attack
   d. interference and distractions
   e. plateaus to some extent inevitable in learning

2. Influence of occurrence of plateaus

   a. stimulation to further effort
   b. may lead to discouragement if not understood
   c. period during which consolidation of knowledge takes place

IV. Factors in the learning process.

A. Principles involved (particularly army application in training) - (Psychology for Fighting Man, pp 229-31).

B. Meaningfulness of subject matter (relation of learning to problems of combat).

C. Active attitudes (coach and pupil method, participation).

D. Knowledge of results always helpful (dry firing, rifle range, etc.).

E. Reward and punishment (principle of law of effect, incentive, etc.).

F. Overlearning (Army's application is to teach so thoroughly that behavior will be instinctive under stress of combat).

G. Integration with pre-existing body of knowledge.

H. Learning by whole method and learning by part method.

I. Variation of ability to learn with increasing age.

1. Youth - optimal time to learn new skills, less interference from pre-existing habits
2. Middle age - the period to add new details to your mental stock, a slight decline in learning capacity but growth in breadth
3. Old age - ability to learn material unrelated to past experiences very low
4. Individual differences are very wide, and some men are capable of considerable learning well on into life. Most men have not reached their capacity to learn.

V. Retention and recall.

A. Importance of sound study habits.

1. Following a definite schedule
2. Shutting out distractions
3. Tie up new things being learned with old knowledge and experience
4. Develop good reading habits (three time reading technique)
5. Overlearn whenever possible
6. Use originality in learning (diagram, paraphrase, abstract)

B. Effect of pleasant or unpleasant associations on memory.

1. Tendency to forget unpleasant experiences
2. Persistence of pleasant associations--nothing succeeds like success

C. Other factors involved

1. Recency
2. Frequency
3. Vividness

EMOTIONS
Lecture 3

Objectives:

I. To explain the development of emotional behavior, stressing its dependence upon learning and environmental experiences.

II. To allay undue fears and anxieties arising from misconceptions of the nature of emotional behavior by explaining the normalcy of emotional responses under varying conditions, and by describing the physiological components of emotional response and the function served by these components.

III. To demonstrate the significance and use of emotions and sentiments in warfare.

Method of Presentation:

I. The evolution of emotional patterns.

A. Theories of native endowment.

1. Watson's three basic emotions and proof

a. fear - initial stimuli are loss of support and loud noises; response is withdrawal reaction
b. rage - initial stimulus is restraint; response is attacking reaction
c. love - initial stimulus is stroking, petting; response is desire to continue the stimulus

2. The theory of an initial generalized emotional response with subsequent development of more specialized responses

B. The development of more complex emotions.

1. The importance of learning (conditioning experiments with reference to fear, etc.)
2. Evolution of basic emotional patterns into more complex patterns of loyalty, comradeship, hatred, romantic love, etc.
3. Process of specialization and refinement of emotions

II. The physiology of emotions.

A. Explain simply the function of the nervous system.

1. The central nervous system (with reference to actions over which we have direct control)
2. The autonomic nervous system (with reference to actions over which we have no direct control)

B. Bodily manifestations of emotion.

1. Describe physical manifestations of emotion produced by the action of the sympathetic nervous system
2. Explain that difference between rage and fear is one of the nature of the reaction to the stimulus in terms of the perception of the stimulus, but that internal physical changes are the same
3. Explain necessity of the functioning of the sympathetic nervous system in extreme situations requiring prolonged physical activity

a. prepares the body for prolonged activity
b. describe how it does this: adrenalin, blood clotting, etc.

III. The effects of emotion.

A. Fatigue - severe and prolonged emotional experiences result in mental and physical fatigue. (refer to sustained action of the sympathetics)

B. Shock - severe emotional disturbance may result in "freeze" or confusion of activity.

C. Personality and emotion - personality traits will influence the type of emotional responses in particular situations (some men will be fearful, others bolder depending on prior experiences).

D. Emotion and personality - emotional reactions affect the development of personality.

IV. The control of the emotions.

A. Social restrictions necessitate some degree of emotional control.

1. The mores determine acceptable emotional response.
2. As we grow up, we learn to control and restrain emotions.

B. Methods of control of emotions.

1. Unsatisfactory methods

a. repression - does not provide necessary outlets of expression
b. "blowing your top" - provides an outlet, but is destructive in nature and may injure others
c. escape into phantasy or temporary relief through drinking - provides temporary relief, but results in development of bad habit and does not permanently solve problem

2. Sound methods

a. control of stimulus - avoid or eliminate situations which irritate or disturb you; when this is not possible, attempt to change your attitude toward that situation so it will no longer be source of irritation
b. instinctive training - the Army method is to overtrain so that required activity becomes sufficiently automatic to assert itself even under conditions of extreme emotional seizure
c. sublimation - channelize emotional response into constructive pursuits. (sports, hobbies, catharsis, work, etc.)

C. Normal and abnormal responses.

1. Explain that normal emotional response is dependent upon the nature of the total stimulus situation. Fear is normal in combat, fear of dogs not usually so. Grief and crying are normal in civilian life at sight of death, more phlegmatic emotional response becomes necessary in war.

2. Usually, over or under emotional responses of extreme nature are symptomatic of things bothering the individual.

CONFLICTS
Lecture 4

Objectives:

I. To show that conflict arises when there is a barrier to the satisfaction of a desire or when there are two conflicting desires within an individual.

II. To stress the importance of resolving our problems because unresolved problems create tensions.

III. The most satisfactory solution to problems are the ones that equip the individual to meet similar situations in the future.

IV. To stress that it is normal to have certain problems in certain situations.

Method of Presentation:

I. The universality of conflicts.

Everyone has problems of one sort or another. Certain types of problems are common and normal to certain groups (e.g., soldiers' problems differ from civilians, children from poor homes have problems different from children from wealthy homes, soldiers in combat have problems different from soldiers in the States.) It is important to realize the normalcy of certain problems because often the feeling that we are alone or wrong in being bothered by something causes undue worry. Cite experience in England where civilian casualties of raids were relieved when convinced that their fears were normal.

II. How do conflicts arise?

A. Briefly review the data on the development of motives (Lecture 3).

B. A conflict will arise when an external barrier blocks the satisfaction of a desire (e.g., want to be a doctor, can't go to medical school; want a certain girl, someone else has her; want to be a pilot, failed the cadet classification test).

C. A conflict arises when there is a clash between two desires (e.g., during unemployment, man wants to eat but wants to be honest and not steal; soldier wants to fight the enemy but also wants to save his life; man may love a woman but thinks it is incorrect to do so because she is married, etc.)

D. A conflict arises because of misconceptions. Our conception of a situation may not actually be the situation. This is evident in such problems resulting in jealousy where there may be no real basis for the distrust and subsequent jealousy.

E. Conflicts result in tensions, irritability, moodiness, blowing your top, etc. The relaxed individual is the happy individual. The tense individual is the one who usually has problems.

III. The resolution of conflicts.

A. We adjust to problem situations in terms of the techniques and behavior patterns we have learned. Refer to Lecture 1.

1. There will be some problem situations that will be so foreign to an individual's experience that he may solve them in a very unsatisfactory way (e.g., running from combat, avoiding girls when a young adolescent, etc.)
2. Generally speaking, the conflict will be resolved because one of the two conflicting desires is stronger and wins out, or because the barrier to satisfaction is removed, or because satisfaction is found in a different manner (symbolically, skirting the barrier)

a. Explain how in animals we can compare strengths of drives
b. drives are of different strength in different individuals, and what may win in one man will not in another (e.g., in most men, desire to save life wins and man refuses to fight)

B. Adequate solution of a problem is measured in terms of the personal satisfaction of the individual concerned, provided it does not conflict with the group welfare.

1. That solution is satisfactory, which in some measure satisfies the basic desire
2. That solution is satisfactory which relieves tension (provided it does not hurt someone else,as in blowing your top)

C. Adequate solution of a problem equips the individual to meet similar frustrating situations in the future. Elaborate by giving examples.

D. Some solutions to conflicts will be only partial. You cannot always have what you want and must make some compromises with desires and standards, and accept this fact.

E. Techniques for resolving conflicts
   1. Changing the enviornmental situation where that is the source of difficulty; it can be changed, e.g. Moving to a new location, giving up certain friends, transferring to a new job.
   2. Changing the attitudes of the individual where they are the cause of the difficulty. This requires a process of analysis by the individual, acceptance of the need for change, and a program of reeducation in habits and attitudes.

MENTAL HYGIENE
Lecture 5

Objectives:

I. To explain some psychological principles that help develop sound mental attitudes.

II. To indicate the importance of applied psychology in mental well-being.

Method of Presentation:

I. Important principles of psychology relating to mental well-being
   A. An individual's personality and behavior are the result of many and complex factors - not always apparent.
   B. Our behevior is learned. We act in ways in which we have learned to act through experience.
   C. Our behvior is an effort to satisfy certain motives and desires, and different people learn to satisfy them in different ways.
   D. Behavior and personality patterns are normal or abnormal depending upon the situation one is in and developmental experiences one had. (These concepts are to be touched upon lightly. The material for them has been covered in the four preceding topics. This section provides a brief introduction to the actual lecture material.)

II. Principles of sound mental health
   A. Good physical health
      1. Sick, physically under par individual more apt to be irritable, moody, and hence emotionally maladjusted.
      2. Physical ailments may become a source of conflict because of personal attitude toward then and worry over them.
   B. Objectivity and Insight
      1. Necessary to look honestly at oneself to understand oneself.

2. Necessary to try to arrive at analysis of motives activating own behavior.
3. Behavior not always simply understood (e.g. blowing your top at your wife may be result of irritation during the day).

C. Catharsis
1. Naive observation has shown all of us value of "talking it out".
2. Psychologically valuable because of experimental extinction.
3. Important to have a person or persons to whom you can go with confidence to discuss problems.
(See references to Shaffer, Psych, of Adjustment, on "catharsis")

D. Normal social participation
1. Necessary to satisfy feeling of belonging to group or to someone.
2. In a group, can forget own problems and joy in group achievement.

E. Aviod moralistic judgments of behavior
1. Better to think in terms of why certain behavior occurs than in terms of is it "right" or "wrong".
2. What is "wrong" leads to a sense of guilt which creates tensions and anxieties. (Illustrate with references to shame at apparent fear, shame over sex, etc.)

F. Living in the present
1. It is normal to do a certain amount of planning and day dreaming.
2. Living in the future good because it gives a purpose to things - but only does so when it is related to activity in the present.
3. It is normal to reminisce about the past.
4. Living in the past bad if it keeps one from living actively in the present (e.g. homesickness, writing excessive letters and avoiding social contacts in the Army).

G. Planned activity
1. Importance because purposeful activity has higher motivation.
2. Importance of ambitions and plan of life.
3. Cuts down on boredom.

H. Recreation
1. A means of relaxation and release of pent up tensions.
2. A feeling of restfulness follows sports participation.

I. Sense of Humor
1. Has a value as a means of tension reduction.
2. Illustrate with anecdotes as to how a joke in a tight situation by relaxing men enabled them to carry on with strenuous task.

J. Awareness of assets and liabilities
   1. Individual's own evaluation of self is major factor in mental health.
   2. Must be aware of limitations - can't succeed at everything - have to accept some defeats as unavoidable.
   3. At the same time, must be aware of abilities - most of us do not perform up to a maximum of our capacities.

K. Application of the scientific method to personal life
   1. Objectivity about self
   2. Analyze situations - collect data
   3. Form a hypothesis for behavior
   4. Evaluate different hypothesis
   5. Select best solution

ADJUSTMENT OF THE RETURNEE
Lecture 6

Objectives:

I. To describe to the returnee some of the major socio-economic changes that have occured in the United States during his absence.

II. To give the returnee an understanding of civilian America's contribution to the war, and to develop a feeling that the entire nation has participated in the prosecution of the war.

III. To indicate the proper ways of channeling some of the returnee's inevitable bitterness with reference to people and conditions in the States.

IV. To afford the returnee an opportunity to express some of his "gripes". (The actual lecture time should be brief, and considerable time should be devoted to group discussion. Let group develop facts in reply to specific "gripes" as they arise.)

Method of Presentation:

I. The importance of realizing that America has changed
   A. The soldier discovers on his first leave that he and his home and community seem out of joint - based on evidence from reports of returnees indicating feeling of strangeness while home.
   B. The soldier overseas develops an idealized picture of the United States with the inevitable outcome of a letdown when he returns.
   C. Returning to the States involves a process of readjustment just as entering the army or going overseas did.

II. The changes that have taken place in American Life
   A. The civilian population has been affected
      1. Tensions because of war sons, husbands, relatives in service.
      2. Rationing and increased cost of living.
      3. Some uncertainty as to the future.

4. Increased mobility among civilians.
5. Some relaxation in moral standards.

B. The economic structure of the country has been affected
1. Intense government participation in industry through regulation.
2. High tax structure.
3. Increased income - cite actual figures showing that increases not as fabulous as may servicemen believe.
4. More money to spend, fewer things to buy, hence rationing and black market.

C. The industrial scene
1. New entrants into the labor market - women, negroes, disabled.
2. Industrial disputes-cite figures to show they have not really been excessive. Cite Gen. Marshall's statement that equipment has never been lacking at front because of strikes.
3. Cite evidence of industrial cooperation-labor-management committees.
4. The manpower situation policies and activities of War Manpower Commission and of Selective Service.

D. The family during wartime
1. Mothers at work, children unsupervised, some rise in delinquency.
2. Crowded housing conditions in boom towns.
3. Straining of family ties and strengthening of ties by common sacrifices.

E. Race relations during wartime
1. Contribution of all races and religions to the war effort.
2. Increase in tension between some negroes and whites.
   a. Harmful effects to country if this is not resolved democratically.

III. America's contribution to the war
A. The fabulous production record due to cooperation of all.
B. The U.S.O., Red Cross and fraternal organizations aiding servicemen.
C. Modern war is fought by all the people - manpower must be allocated between armed forces and industry and agriculture. A doctor cannot be expected to be an infantryman, a 4F has a different contribution to make than a soldier, etc.

IV. Some aspects of life in the states that may seem wrong to servicemen
A. Civilians have not sacrificed as directly as soldiers.
B. People here still have money and good times.
C. Civilians are not living under restraints the soldier

lives under.

D. Many individuals seem selfish and are making a profit out of war.

E. Black markets and evidence of non-patriotism.

V. The soldier analyzes the situation

A. The soldier is bitter because he has sacrificed and suffered more.

1. Bitterness should be directed against the men and nations who caused the war, rather than against scapegoats at home.

B. Cautions the soldier should employ in evaluating things

1. Often problems are more in imagination than real - are people all getting rich, are wages fabulously high?

2. Can everyone sacrifice equally in this war? Do we want America bombed? Most people are giving a good deal to the war - sons in service, war bonds, taxes, etc. Soldiers usually feel their folks are behind war, why not then assume other people's folks are too?

3. Don't generalize about people from single observation:
Miami Beach not typical of all U.S., all civilians aren't same, all members of minority groups aren't same, generalizations are dangerous because usually based on inadequate observation and a few glaring bad points.

C. What might the soldier do

1. Catharsis - relating things he has seen at first hand may bring awareness of war home to people here.

2. Activity in behalf of what he believes in will help relieve his sense of frustration.

3. Keep directing hatreds against the enemy, not against homefolk.

VI. Discussion:

INDIVIDUAL ABILITIES
Lecture 7

Objectives:

A. To explain differences in abilities, with particular reference to occupational skills and qualifications.

B. To explain the basic techniques underlying psychological tests and the theory upon which prediction from test scores is made.

C. To give a general explanation of the principles of job assignment in the Army.

Method of Presentation:

I. The distribution of abilities

A. Explanation of the normal curve.
B. General discussion of differences between individuals
   1. Types of abilities that distribute according to normal curve.
   2. Characteristics that do not distribute according to the curve.
C. General discussion of differences of abilities within individuals.
   1. Individuals are not equally good at all things
   2. Wide range of abilities within an individual
   3. Implication is that there are many things a person can do with adequate ability.

II. Intelligence and its measurement
A. Give a number of sample definitions of intelligence, stressing concepts of learning, utilizing past experiences, and solving new situations.
B. Explain Thorndike's classification of types of intelligence
   1. Abstract or verbal - its application and manifestations.
   2. Mechanical - its applications and manifestations.
   3. Social - ability to deal with people and life situations.
C. Methods of measuring intelligence
   1. In terms of the level of difficulty of problems the individual can solve.
   2. In terms of the speed with which an individual can solve problems of equal difficulty.
   3. In terms of a combination of the above two factors.
   4. The difficulty of determining exactly what we are measuring.
   5. Most tests of intelligence are measuring so-called verbal or academic intelligence.
D. Application of intelligence test performance
   1. Explanation of the intelligence quotient, and limitations with reference to adults.
   2. The concept of comparing an individual's performance with members of his own group (percentile technique)
   3. G.C.T. scores by groups.
   4. Intelligence score is indicative of a theoretical upper limit of learning capacity; actually most of us can do a lot better than we have in terms of learning, in that few of us have reached our maximum level.

III. Aptitudes and their measurement
A. Meaning of aptitude
   1. The capacity to do well at a particular skill or occupation.

2. We attempt to predict an individual's capacity to succeed at a particular occupation by trying to measure his aptitudes.

B. Types of aptitudes
1. Manual aptitudes - characteristics.
2. Mechanical aptitudes - manual plus intellectual factors which distinguish engineer from mechanic, machinist from manual worker.
3. Clerical aptitudes.
4. Literary aptitudes.
5. Artistic aptitudes.
6. Musical aptitudes.
7. Scientific aptitudes.
8. Aptitude for sports.

C. Are aptitudes inborn or acquired?
1. Evidences to indicate they are inborn, but,
2. Aptitudes must have a soil to flower in.
3. Most vocational skills, not of extremely high degree, can be acquired given reasonable physical and mental ability and opportunity for learning.

D. Methods of measurement of aptitudes
1. We measure aptitudes by measuring present performance on a test and correlating it with future performance on a job.
2. Present achievement is a measure of aptitude.
3. Performance on a job sample is a measure of aptitude.
4. Performance on a related job is indicative of potential skill (job family concept).
5. We can construct aptitude tests by seeing how good and poor workers in a particular occupation perform on the test.

IV. The nature of interests
A. Interests are important from the point of view of motivation.
B. Interests may change - cite some date on permanency and changes of interest with age and experience.
C. We attempt to measure interests by comparing an individual's likes and dislikes with those of successful workers in particular fields (technique of construction of Strong inventory).
D. Interest may develop as the result of army experiences.

V. Basic concept of classification and assignment
A. Classification evaluates a man's skills and potentialities.
B. His abilities are then matched up against available jobs.
C. The condition of the labor market (quotas in the case of the army) may decide particular matching of men and jobs.

Assignment to a sceondary skill is often necessary, and not poor, because man has more than one occupational skill that the Army can use.

VI. What can psychological tests tell us?
A. They can indicate limitations in capacities.
B. They can indicate probabilities of success or failure-tests are so constructed statistically that they indicate a probable factor, e.g. most people scoring high on this test do well in this occupation, therefore a surmise may be made for the particular individual.

MILITARY PSYCHOLOGY-MORALE
Lecture 8

Objectives:

1. To develop the concept that morale depends upon personal adjustment and satisfaction, a feeling of belongingness, and sound indentification with the group purpose, i.e. successful prosecution of the war.
2. To explain the factors involved in the morale of our enemy and to describe the problems we face in trying to break that morale.

Method of Presentation:

I. The nature of morale
A. Morale in its broad sense, is the sound adjustment of the individual within the overall framework of the group. It embraces all the concepts of sound mental hygiene. In its specific applications (industry, war, sports, etc.) it presents problems peculiar to the immediate activity.
1. Morale is fundamentally a problem of individual adjustment.
2. Individual and group morale interact and affect each other.
3. Low morale is a symptom of dissatisfied individuals and groups.
B. Problem of army morale in a democracy
1. Frustrations aroused in the "civilian in uniform" by restrictions on personal freedom. Danger is that hostility will be directed against army rather than against Hitler and Hirohito, who are responsible for men being in the army.
2. Democratic orientation toward peace makes for difficulty in soldier's acceptance of "kill or be killed" philosophy.
C. Enemy morale
1. High, because of life long training and discipline - for war.
2. Easier to maintain because of rigid control exercised

by the totalitarian state (secret police, controlled press, etc.).

3. Inculcated ideals of Nazi and Japanese states are firmly believed by people because of rigid conditioning and propaganda.

II. Factors involved in morale

A. Physical condition of the individual.

B. Initial incentive - mass suggestion, war hysteria, combativeness, public opinion, self respect, patriotism, political conviction.

C. Social incentive - desire for approval, fear of disapproval, sense of responsibility.

D. Belief in why we fight - most important is the individual's personal satisfaction that his cause is just and right.

E. Belief in democratic ideals - submission of will to majority.

F. Group contagion - "greater than fear of injury or death is the fear of shame" (Napolean).

G. Emotions and sentiments in morale - hate directed against the enemy, loyalty to country, comradeship with group, etc.

III. Uses and effects of morale

A. Our Army's attempts to build high morale

1. Orientation programs, discussions, training films, etc., designed to give an understanding of background and necessity for fighting.

2. Inculcation of respect for, knowledge of, and confidence in the things for which we fight.

3. In pre-combat training, develops in men a sense of security and confidence in themselves and in their unit.

4. Officers and instructors schooled in giving the soldier a feeling of individual usefulness and belonginess within the group.

5. Democratic traditions stressed.

B. How the enemy attempts to weaken our morale

1. Plays upon frustrations inherent in the democratic "civilian turned soldier" set-up.

2. Attempts to turn this frustration into self-destructive anger within ourselves.

3. Uses propaganda to divide us, to set us to arguing among ourselves.

C. How we attempt to weaken enemy morale

1. Discourage his belief in possibility of victory by constantly reminding him of our strength, and his defeats.

2. Shake his faith in the infallibility of his leaders.

3. Get him to fix the blame for his plight upon his leaders.
4. Invite him to escape the harships of fighting a lost cause by surrendering or turning against his leaders.

D. How the enemy keeps up its own morale
1. Harping on the "superman" myth - "we can't lose", Hitler's intuition, etc.
2. Fear - of the Gestapo and of the conditions of unconditional surrender. Explain why unconditional surrender necessary, but that it is distorted by the Nazis to mean they will become slaves.
3. The sancity of the "homeland" theme - the "sacred" Rhine, no one has ever crossed it.
4. Nazi word magic - Nazi and Jap fanaticism.

MILITARY PSYCHOLOGY - PROPAGANDA
Lecture 9

Objectives:

1. To demonstrate the importance of propaganda, particularly as a weapon in warfare.
2. To explain the psychological technique employed in propaganda.
3. To discuss and evaluate the types of propaganda that adversely affect morale, hamper the war effort, and hinder the organization for effective peace.
4. To provide some guidance for analyzing and evaluating any type of propaganda.

Method of Presentation:

I. Propaganda as a weapon of war
A. Coexistent with the military, economic, and political fronts in modern warfare, there ixists a psychological front, which utilizes propaganda as its major weapon.
B. Illustrate the importance of propaganda in modern war with reference to the German Ministry of Propaganda, British Ministry of Propaganda, the Office of War Information, Bureau of Psychological Warfare, etc.
C. The Nazis were the leaders in the use of psychological warfare in their early conquests, and in their continuing efforts to divide the allies. We, too, have begun to affectively employ propaganda.

II. Sources of propaganda
A. Press - differentiate between the controlled press of totalitarians, and the free-press of the democracies. Use of leaflets in psychological warfare.
B. Radio - offers broadest range of contact today. Discuss its use in this war (Tokyo Rose, Sally from Berlin, Lord

Haw-Haw, "Listen Hans").

C. Pulpit - may be source because the receptive attitude produced by religious mental set of audience makes them receptive to non-religious concepts introduced parenthetically.

D. Theatre - lowered suggestibility threshold is occasioned by the expectation of entertainment.

E. Literature - differentiate between literature designed as entertainment and that deliberately aimed at one as propaganda. First may be more subtle and insidious.

F. Platform - importance of the face-to-face approach and direct contact. On the other hand, we usually know what a speaker at a political gathering is there for, and are less suggestible.

G. Grapevine - most effective source for the dissemination of more subtle forms, i.e., rumors, suggestions, hints, and insinuations. Most difficult to counteract.

III. Psychological techniques employed in propaganda

A. Scapegoat technique - utilizes displacement or transfer of emotion (illustrate with Nazi-Jew baiting).

B. Bandwagon - takes advantage of feelings of insecurity and desire to "belong" (illustrate with elections, Japan's Greater East Asia Co-Prosperity Sphere).

C. Divide and conquer - plays upon fears and hatreds to lower motivation and create confusion of aims and ideals (illustrate with Fifth Column).

D. Glittering generalities - utilizes psychological concept of identification, through unspecified but enticing promises.

E. Technique of "big lie" - when you tell a lie, tell a big one.

F. Loaded words - takes advantage of tendency to stereotype.

G. Name calling - association with other stereotypes.

IV. Methods of disseminating propaganda

A. Partial truths - build a receptive audience by giving some truths, then slip in a lie.

B. Suggestion - attempts to stimulate acceptance without logical analysis, through use of hints, insinuations, indirect statement, rumor, etc.

C. Slogans - make ideas stick through use of short, appealing words or phrases.

D. Symbols - concrete representation of the ideas for which acceptance is being sought.

E. Prestige - tendency of people to identify themselves with famous and important persons is utilized. Also, halo effect.

F. Mass hypnotism - combination of most effective of above techniques may result in mass subjection of will. Use

of mass functions, parades, etc.

V. Use of propaganda as a weapon in warfare

A. As a tool in promoting a national war effort
1. Establish recognition of a common purpose.
2. Build cohesive strength.
3. Maintain healthy morale.
4. Lasting peace.

B. As a tool in demoralizing
1. Disunity rumors (international) - propaganda designed to create disunity between allies.
2. Disunity rumors (national) - propaganda designed to revive and fan flames of old hatreds and prejudices: anti-Semitism, anti-Catholicism, anti-Negro, anti-capitol, anti-labor, etc.
3. Defeatist rumors - propaganda calculated to destroy faith in military leadership, national leadership, military equipment, etc.
4. Narcotic rumors - designed to foster smug complacency.

C. As a weapon in combat
1. Field propaganda units (enemy uses and ours).
2. Leaflets and newspapers for enemy consumption.
3. Short wave radio.

VI. Analysis of propaganda

Propaganda is anything which attempts to influence people to accept or change ideas. Propaganda and counter propaganda have created confusion and insecurity in the minds of individuals. There are safeguards against this, and clues and techniques to employ in analyzing propaganda. Some of these are:

A. Who is making the statement and why?
B. Are the statements true? Can they be verified objectively?
C. Is the propaganda relevant to the situation?
D. Is the propaganda selfish or unselfish in motives?
E. What will be the effects of the action we are asked to take?
F. Is the propaganda intended to lead to rational thinking or to emotional action?

* * *

In working out these topic outlines the staff of the Section cooperated with the psychiatrists so that the material presented to the patient might be acceptable to all those persons charged with his welfare. This involved omitting reference to marital problems and emphasizing the development of operational fatigue and problems of readjustment to the U.S.A.

During the period when this new series was in effect, it became necessary to change the scheduling procedure. In presenting the series

in semi-weekly lectures, the average length of stay for patients in the hospital was assumed to be at least five weeks, and in fact, this was the case when the new series was inaugurated. But as the patient load increased and local policies changed the average stay dropped to about three weeks. In order, then , to insure the patient's receiving the full series, it was found necessary to schedule continuous orientation on a daily basis for two weeks.

There were other advantages in this proposed revision in scheduling:

1. It standardized the classes, with all men entering at the same point in the course and completing the course as a class unit, which had not been done before.

2. It provided for better transition from lecture to lecture by having them come in rapid sequence, daily for two weeks.

3. It made for more efficient utilization of space in the lecture room. Under this new plan it was possible to conduct both initial and continuous orientation in the same room.

This new policy was adopted on 24 January 1945.

The ten lecture-discussions were begun for each patient either shortly after admission or, in cases the personal physician feels are not ready for the course immediately upon arrival, when the personal physician decides the man might enter the course.

The ten lectures were then given consecutively one hour a day for ten days. There were four classes running concurrently at 1000, 1100, 1300, and 1500 hours. The classes were so arranged that a new class began every second or third activities day (this excluded Saturday and Sunday). Men were, in all but special cases presenting scheduling difficulties, admitted to a class only at the start of that class.

The classes were so arranged that the program placement interviewer had a choice of recommending assignment of a new patient to one of three classes at any given time. These classes began in most instances, from one to four days after the man's initial interview. This type of scheduling was worked out after coordination with the Plans and Schedules Office, the Physical Reconditioning Branch, and the Education Branch, and in the end resulted in a smoothly functioning plan of operation.

The last and final revision of the orientation outline came on 25 March 1945. This last change was not so much a revision as a condensation. The patient load in the hospital again decreased, the type of patient changed to include more men classified as suffering from mild operational fatigue, and the average length of stay dropped. To condense the orientation series into five sessions was therefore to insure the patient getting a complete series and to avoid vexatious scheduling

problems. Accordingly, on 26 March, a new outline was prepared to enable the staff to present as much of the former material as possible in the new five-session series, briefly outlined below.

I. Understanding Human Nature

How our personalities develop. An explanation of behavior in terms of efforts by the individual to satisfy desires and motives. Emphasis on the concept of behavior patterns and personality developing as the result of the reactions of the individual to enviornmental stimulations. Acquisition through learning of habits and attitudes. Changing of habit patterns by re-education.

II. Understanding Our Emotions

The development of emotional responses and the role of the emotion in preparing the body for activity. The control and utility of the emotions in the army and under combat conditions. The physiology of emotions. Oporational fatigue and the psychology of emotions.

III. Adjusting to Difficulties

How personal problems arise, with special reference to army life and how the individual may resolve these problems. The thwarting of important drives and the effects of this thwarting. Conflicts between different drives and the effects of these. Analysis and discussion of major army and combat conflict situations. Proper use of various mechanisms of adjustment.

IV. The Servicemen, the War, and the Nation

Discussion hour aiming to re-establish basic identity between serviceman and the nation. Discusses some of the forces tending to alienate serviceman and civilian. Demonstrates techniques of propaganda that may be used to foster disunity and undesirable attitudes with reference to the essential interests of the nation. Indicates provisions that are being made for the returned or discharged soldier such as the GI Bill of Rights. Brings out the facts relating to the total war effort by all the people of the country. May discuss problems of post war import to direct the soldier to think positively in terms of a future to come out of the war, a democratic and purposeful future for him and the country.

V. The Adjustment of the Returnee

Lecture and discussion of some of the psychological changes that may have occured as the result of overseas and combat experiences. Analysis of psychological factors involved in making adequate readjustment to the States, families, civilians, soldiers continentally stationed, etc. Discuss some established principles of sound mental hygiene. Points out the normalcy of acquiring certain combat reactions which may persist for a time after return to the States. Brief explanation of some of the principles of learning as related to the returnee with regard to utilization of old skills, relearning, and transfer of skills to new fields of endeavor.

The method of presentation as outlined is followed at all times, but is combined with an informality designed to erase the suggestion of a classroom situation and develop the easiest and freest kind of rapport. To that end, on 1 June 1944, the student armchairs were removed from the classroom and they were replaced with confortable chairs and sofas calculated to foster an atmosphere of informal discussion.

STATISTICAL SUMMARY
ORIENTATION FUNCTIONS, UNITS T,N,B

TABLE IX
ORIENTATION I AND II, COMBINED

Date	No. of Patients			No. of Sessions	No. Session Hours
	O	EM	T	T	T
28 Oct. to 2 Dec.	41	265	306	41	41
3 Dec. to 9 Dec.	9	30	39	5	5
10 Dec. to 16 Dec.	18	16	34	5	5
17 Dec. to 23 Dec.	5	22	27	5	5
24 Dec. to 30 Dec.	3	43	46	4	4
31 Dec. to 6 Jan	7	34	41	4	4
7 Jan. to 13 Jan.	17	88	105	5	5
14 Jan. to 20 Jan.	14	53	67	5	5
21 Jan. to 27 Jan.	17	54	71	5	5
28 Jan to 3 Feb.	19	91	110	5	5
4 Feb. to 10 Feb.	24	117	141	10	8
11 Feb. to 17 Feb.	20	130	150	5	5
18 Feb. to 24 Feb.	26	104	130	10	10
25 Feb. to 3 Mar.	11	87	98	7	7
4 Mar. to 10 Mar.	21	135	156	14	12

TABLE IX CONTD.

Date	No. of Patients			No. of Sessions	No. of Session Hours
	O	EM	T	T	T
11 Mar. to 17 Mar.	94	73	167	15	12
18 Mar. to 24 Mar.	36	74	110	28	26
25 Mar. to 31 Mar.	8	31	39	10	19
1 Apr. to 7 Apr.	8	65	73	15	19½
8 Apr. to 14 Apr.	16	41	57	20	20
15 Apr. to 21 Apr.	16	33	49	11	11
22 Apr. to 28 Apr.	24	55	79	14	25
29 Apr. to 5 May	35	78	113	16	25
6 May to 12 May	25	107	132	15	22½
13 May to 19 May	23	101	124	14	22
20 May to 26 May	19	76	95	13	19
27 May to 2 June	14	70	84	14	23
3 June to 9 June	11	89	100	15	22½
10 June to 16 June	6	85	91	14	23
17 June to 23 June	12	54	66	12	21
24 June to 30 June	12	38	50	12	15

ORIENTATION FUNCTIONS, TOTALS

TABLE X

ORIENTATION I & II COMBINED

	O	EM	T
No. of Patients	611	2339	2950
No. of Sessions			368
No. of Session Hours			451½

STATISTICAL SUMMARY
ORIENTATION FUNCTIONS, UNIT T

TABLE XI
ORIENTATION III

Date	No. of Patients			No. of Sessions	No. of Session Hours
	O	EM	T	T	T
28 Oct. to 2 Dec.	33	109	142	16	16
3 Dec. to 9 Dec.	25	153	178	16	16
10 Dec. to 16 Dec.	25	130	155	16	16
17 Dec. to 23 Dec.	29	83	112	16	16
24 Dec. to 30 Dec.	16	90	106	12	12
31 Dec. to 6 Jan.	12	100	112	12	12
7 Jan. to 13 Jan.	20	148	168	16	16
14 Jan. to 20 Jan.	30	168	198	16	16
21 Jan. to 27 Jan.	23	108	131	16	16
28 Jan. to 3 Feb.	18	77	95	18	18
4 Feb. to 10 Feb.	40	68	108	17	17
11 Feb. to 17 Feb.	38	89	127	12	12
18 Feb. to 24 Feb.	29	96	125	21	21
25 Feb. to 3 Mar.	16	76	92	10	10

TABLE XI cont.

Date	No. of Patients			No. of Sessions	No. Session Hours
	O	EM	T	T	T
4 Mar. to 10 Mar.	19	42	61	20	20
11 Mar. to 17 Mar.	72	32	104	20	20
18 Mar. to 24 Mar.	36	29	65	12	12
25 Mar. to 31 Mar.	9	62	71	9	9
1 Apr. to 7 Apr.	21	24	45	11	11
8 Apr. to 14 Apr.	4	50	54	15	15
15 Apr. to 21 Apr.	6	24	30	7	7
22 Apr. to 28 Apr.	22	49	71	14	14
29 Apr. to 5 May	24	32	56	10	10
6 May to 12 May	27	46	73	12	12
13 May to 19 May	25	58	83	12	12
20 May to 26 May	18	63	81	13	13
27 May to 2 June	16	50	66	12	12
3 June to 9 June	5	29	34	10	10
10 June to 16 June	2	46	48	10	10

TABLE XI. cont.

Date	No. of Patients			No. of Sessions	No. Session Hours
	O	EM	T	T	T
17 June to 23 June	6	49	55	10	10
24 June to 30 June	6	27	33	10	10

ORIENTATION FUNCTIONS, TOTALS

TABLE XII

ORIENTATION III

	O	EM	T
No. of Patients	672	2207	2879
No. of Sessions			421
No. of Session Hours			421

EVALUATION AND PROGRAM PLACEMENT SECTION FUNCTIONS, UNIT T

I. Purpose:

The present methods of the Evaluation and Program Placement Section are designed to accomplish the following objectives:

A. To secure in an initial interview personal, occupational, and educational data on each patient so as to permit efficient and correct placement of the patient in the convalescent activities program, and to provide normative data on the abilities and interests of the patients so that the educational program and administrative procedures can be designed to meet such abilities and interests.

B. To evaluate in a terminal interview the patient's physical and emotional progress during his hospitalization and to determine and interpret his present limitations and attitudes as regards further duty, combat, and the like so that recommendations for assignment and disposition can be made to the Classification and Military Assignment Branches of the Redistribution Station.

C. To interview patients regarding breaches of discipline and failure to attend classes so as to correct mal-assignments and help solve personal problems, and to provide the Administrative Branch with information regarding the causes and corrections of such behavior.

D. To provide the patients with adequate counseling on educational and vocational problems.

E. To obtain adequate social case histories from all operational fatigue patients, and all other types of patients for whom personal maladjustment is a major factor in their convalescence, so as to provide the psychiatrist with a basis for treatment and disposition.

F. To secure identifying and personal data on each patient for the Research Section in the development and evaluation of tests.

II. Organization:

The Evaluation and Program Placement Section at Unit T consists of one officer in charge and four enlisted men. When the flow of patients demands it, additional men from other sections are temporarily assigned to this duty. The personnel were selected largely on the basis of their experience and training in the fields of clinical and personnel psychology. The mechanics of the Section are organized in the following manner and are outlined in the accompanying Flow Chart:

FLOW CHART UNIT T

TABLE XIII

INTAKE PROCESSING

0900 to 1115 Initial Orientation
1. Greetings: Chief, Convalescent Services Division
2. Film: "Out-Of-Bed Into Action"
3. Talk: "Convalescent Hospital', illustrated
4. Tour of Hospital

1300 to 1530 Initial Evaluation
1. Tests
   a. Attitudes Scale
   b. Conv. Personal Inventory
   c. Activity Preference List
   d. Mental Dysfunction (selected patients only)
2. Interviews
   a. Evaluation of Aptitudes & Interests
   b. Evaluation of Attitudes & Adjustment
   c. Program Placement
3. To Plans & Schedules Section by 1530

FOLLOW-UP

1. Supplementary Interview
   a. Program Changes
   b. Educational & Vocational Counseling
   c. Personal Counseling
   d. Delinquent Patients
2. Supplementary Tests
   a. Educational & Vocational Diagnosis
   b. Mental Diagnosis
   c. Personality Diagnosis

Selected patients on own request or referral, by appointment

CONVALESCENT ORIENTATION

Series of 5 Lectures and Discussions
1. Psychology of Adjustment
2. Re-orientation to the U.S.A.
3. Re-orientation to the Army

All patients except selected severe fatigues.

DISCHARGE TO DUTY

1. Terminal Evaluation Tests
   a. Adjustment
   b. Attitudes
   c. Activity Preferences
   d. Mental Dysfunction
2. Terminal Interviews
   a. Evaluation of Adjustment
   b. Evaluation of Program
   c. Readiness for Duty & MOS
   d. Report to Redistribution

All patients returning to duty. By appointment.

30 June 1945

A. Receiving Interview: Each new patient sees the receiving interviewer after admission to the Unit and medical processing, and is scheduled for the various processing activities in the Branch. The receiving interviewer assigns the patients to the various interviewers, initiates the various interviewing forms, and coordinates the flow of men to Initial Orientation, to the Testing Section, and to interviews. He is charged with checking each patient's class assignment for accuracy and the availability of classes, filing of all forms, maintenance of the locator files, and the scheduling of all men for re-interviews.

B. Initial Interview: The initial interview consists of two phases, the completion of the Interview Face Sheet and the planning of an activities program. This is done for all types of patients.

(1) The Interview Face Sheet (Form PSY-IRF 6) appended at the end of this section, contains information on the occupational and educational experience of the patient relevant to program placement. Its main function, however, is to provide basic data as to the range of experience and service and the plans and interests of the patient so that the various branches of the Convalescent Services Division can plan their programs accordingly. Summaries of the information are prepared periodically and distributed to interested branches. It is planned that the contents of this form will vary as new problems and questions of policy arise.

(2) Each patient, unless excused by his physician, is scheduled for three hours or more of activities in addition to physical training. This is done by the interviewer who gives primary consideration to the interests of the patient but who also takes into consideration the abilities, educational, vocational, and avocational experiences, and physical and mental handicaps as determined in the interview.

C. Case Histories: For each operational fatigue case, a social case history is prepared and forwarded to the psychiatrist. In taking this history, the interviewers are guided by a Guide for Case History Taking which contains in outline form the relevant aspects of the patient's army, educational, occupational, and developmental history, and his emotional reactions to be considered in making a judgment as to the degree of present maladjustment and of predisposition to maladjustment. At the request of the psychiatrist, it is planned that this outline will be developed into a standardized biographical data sheet to be used for research on the personality make-up of operational fatigue cases as contrasted to non-operational fatigue returnees, and as a basis for the development of an emotional maturity scale. A similar case history is taken on other types of patients who show symptoms related to problems of adjustment.

D. Supplementary Interviews: Periodically, lists of patients showing delinquency in class attendance and like breaches of discipline are submitted to the Evaluation Section. These patients are interviewed to determine the reason for such delinquencies, to orient the patient to the purposes and benefits of the program, and to take any corrective steps necessary to secure adequate participation. Copies of this interview and the corrective measures taken are submitted to the Chief of the Convalescent Services Division for informational purposes.

E. Counseling: Personal, educational, and vocational counseling are entirely voluntary services. The patients are informed of the guidance facilities during Initial Orientation and the initial interview, and are free to seek such help at any time. The patient is usually assigned to the officer in charge of the Evaluation Section for counseling but may be assigned to any member of the staff qualified to help him. Many of the problems presented hinge about questions of adjustment and personality rather than aptitudes and job opportunities. Extensive use, however, is made of the Army Vocational Information Kit and of vocational and educational tests. Summaries of the interviews, test results, and recommendations are prepared on the Supplementary Interview Sheet and where relevant, the data are submitted to the personal physician with whom conferences are held in cases of personal counseling. Numbers counseled and amount of time devoted to such counseling, are shown in summary of Testing Functions.

F. Terminal Interviews: Upon discharge from the hospital, each patient is interviewed to determine (1) his reaction to the hospital, the activity program, and his treatment, and (2) his attitude toward and fitness for return to duty.

1. For each patient a Terminal Interview Record is filled out analyzing his present physical and mental condition, his reaction to criticism of and participation in the various aspects of the Convalescent Program. In obtaining these data the interviewer is guided by a set of standardized questions so that reliable ratings can be made of the various aspects of the Hospital. Relevant comments, suggestions and criticisms are recorded. These data are periodically analyzed and submitted to the Chief of the Convalescent Services Division and the various branches for their information and guidance.

2. The patient is interrogated as to his present attitudes, handicaps, and general fitness as related to further duty, combat and assignment. In cases where return to full duty in his previous Military Occupational Specialty seems inappropriate, his records are analyzed to determine possible alternative assignments and training in keeping with his

abilities, interests, and present condition. These data and recommendations are entered on the Hospital Summary Sheet which is then submitted to the Classification and Military Assignment Branches of the Redistribution Station. Sample case records follow, illustrating evaluation, program placement, and vocational counseling functions. Names of patients and places, dates and other data have been changed to prevent identification of patient. Sample forms are appended, following the case records.

Case No.:		
INT	TIME	
DATE		

PROGRAM PLACEMENT AND PSYCHOLOGICAL BRANCH

INTERVIEW FACE SHEET

TESTS	
Initial	Terminal

AGE NAME RANK WARD SURGEON DIAGNOSIS

1. Source: P( ) N( ) B( ) Other:_____

2. Time in Miami:_____days

3. Previous Hospitalization: Y( ) N( )

4. Enlisted( ) Inducted( ) Reserve( )

5. Total Army service:_____months

6. Total overseas service:_____months

7. Date returned from overseas:_____

8. Theater: ETO( ) SWP( ) Other:_____

9. Branch of service: AF( ) GF( ) SF( )

10. Last duty:_____

Time at duty:_____months

11 Flying status: F( ) NF( )

12 Time at service schools:_____weeks

13 Other duty assignments:

_____,time:_____months

_____,time:_____months

14 Educational level:_____years

Course:_____

_____

15. Reason for leaving school:

Grad.( ) Econ.( ) Lack of Int.( ) Other:

_____

16. Return to school: Y( ) N( ) ?( )

High School( ) College( ) Other:

_____

Subject:_____

17. Depend on GI bill: Y( ) N( ) ?( ) Part( )

18. MCO:_____

Time at:_____yea

Avail.: Y( ) N( ) ?( ) Wants: Y( ) N( ) ?(

19 Occupational plans: Old( ) New( ) ?( )

20. Remain in army: Y( ) N( ) ?( )

21. Home state:_____

22. Home community: Farm( ) Village( )

Town( ) City( )

23. Return to same( ) other( )_____?(

24. Marital: S( ) M( ) W( ) D( ) Sep( )Time:__

Children: Y( ) N( ) Other Dep.: Y( ) N( )

25. Recommendations:

	First Schedule	Second Schedule
0900	_____	_____
1000	_____	_____
1100	_____	_____
1300	_____	_____
1400	_____	_____
1500	_____	_____

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26. Description of illness or injury:

Limitations:

27. Evaluation of attitudes: *(To be filled out for patients OTHER than ANX)*

28. Remarks:

DATE

Case #_____ PROGRAM PLACEMENT AND PSYCHOLOGICAL BRANCH

SUPPLEMENTARY INTERVIEW RECORD

NAME:_____Rank:_____Ward*:_____Surgeon*:_____

Interviewed By:_____For:_____

NOTES

*-Fill in only on forms to be sent to Ward Surgeon.

PSY-IRF-2C

PROGRAM PLACEMENT AND PSYCHOLOGICAL BRANCH

TERMINAL INTERVIEW RECORD

CASE NO._____ DATE_____

Name:_____ Rank:_____Interviewer:_____

A. 1- Change of condition: CI NI W _____

Weight: Gn Lst Sm Amt.:_____

Sleep: Im Sm W _____

Appetite: Im Sm W _____

Fatigue: Im Sm W _____

Headaches: Yes No _____

Emotion: Im Sm W _____

(Orth): Im Sm W _____

2- Further Hosp.: Yes No _____

3- Medical Treatment: Yes No _____

4- Time of Discharge: Early Ext Amt:_____

5- Assignment: Def Indef Disch _____

6- Duty: Full Limited _____

B. Shops & Classes: Yes No _____

1- Worth: Yes ? No _____

2- Evaluation:
Instructors: Sat Dis _____

Mat. & Equip.: Sat Dis_____

Teach. Meth.: Sat Dis _____

3- Prefer Organ. Inst?: Org Sm _____

4- Absent?: _____

5- Voluntary?: Yes No _____

C. Worth of PT: Yes No _____

1- Activities:_____

2- Sug. & Crit.:_____

3- Org. Instr.?: Org Sm _____

D. Worth of Recreation: Yes No _____

1- Army:_____

2- Civ.:_____

3- Sug. & Crit.:_____

4- Expense: Yes No _____

PSY-IRF 7 (Front)

E. Satisfaction with Hospital: YES NO _____

1- Wards: Sat Dis _____

2- Hospital: _____

3- Organization: _____

4- Passes: Yes No _____

F. Wives: Yes No _____

1- Use Cott Mess Ent Classes _____

2- Lectures: Yes No _____

3- Sug. & Crit.: _____

4- Apartment: Yes No Found: _____ Expense: _____ Time: _____

Satisf.: _____

G. Mess Hall: Yes No _____

1- Meals; Average No.: _____

2. Sug. & Crit.: Sat Dis _____

_____

H. Other considerations and remarks:

HOSPITAL SUMMARY
PHYSICAL, EDUCATIONAL, PSYCHOLOGICAL

Name _____ Grade _____ ASN _____

PHYSICAL FITNESS TEST

Physical Fitness Classification: 1 2 3 4

AAF Physical Fitness Test Score _____ Rating _____

Harvard Step Test Score _____ Rating _____

Remarks: _____

EDUCATIONAL AND AVOCATIONAL ACTIVITIES

Courses: Appraisal:

_____ _____

_____ _____

_____ _____

PSYCHOLOGICAL EVALUATION

Attitude toward return to duty: _____

_____

_____

Aptitudes and interests of possible significance in assignment:

_____

_____

_____

RCH Form No. 168-21
(Old No. 130-21)
Rev. 18 May 1945

_____
OIC, Program Placement
and Psychological Branch
AAFRCH, Miami District

PROGRAM PLACEMENT AND PSYCHOLOGICAL BRANCH
UNIT T

NAME: Davis, Charles M., Case #1941 WARD: 31 MED OFF: Capt. Gill

INTERVIEWER: Pfc. Leskowitz DIAGNOSIS: OF DATE: 7 May 1945

GRADE: 1st Lt. MOS: Pilot, B-17
OVERSEAS SERVICE: 7 Months
AIR FORCE: 15th THEATRE: Med.
MARITAL: M

COMPLAINT: Has been suffering from diarrhea ever since he received his commission in December 1943 at Maxwell Field, Alabama. Began to get gastro-intestinal pains at a rest camp after completing his 20th mission. Says he cannot find reasons for his complaints and that the flight surgeon told him it may be because of his feelings of insecurity as to his future.

OVERSEAS EXPERIENCE AND ATTITUDES: Piloted B-17 with 8th Air Force for 7 months, flying 37 sorties or 55 missions. Has been lucky on most of his missions for he never had an engine conk and none of the crew in his plane were injured or killed by enemy action. Lost his aerial engineer by suffocation in a turret accident on a lone wolf mission. His complaints did not correlate with any mishaps that occured and seemed to increase when he drank alcohol or carbonated water. Had an attack of diarrhea the other day when he had two bottles of beer and two bottles of Pepsi Cola the previous evening. The attacks cease for a few days but always return.

EDUCATION AND CIVILIAN OCCUPATION: Completed high school and thought himself too smart for additional schooling. Regrets that he did not continue school and go to college. Was quite successful as a salesman in children's apparel before entering the service. Is uncertain as to his future occupations for he does not know what he'd like to do upon his return to civilian life. Would like to remain in the Army until he could make up his mind. Has to consider his wife and 2-year old child in making his choice. May consider some additional schooling but only even-courses. Recommended Kuder and General Educational Development tests as possible aids.

BACKGROUND: Always in top 5 of class in high school. States father worked for years in department stores until he saved enough to start retail business. Lost everything because he was unwilling to borrow from friends. Now working again in department stores. Patient states he didn't want to go to school. Apparently lacked funds to go but says, "Anyone can earn his way if he wants to!" Started out in retail trade--swept floors, waited on customers, was traveling salesman, etc. Apparently successful at all this. Married Miami girl. Father-in-law has retail dress shop on Lincoln Road and supposedly clears $10,000 a year. Family has maid and cook. Wife has never had to work, cook, etc.

Has two year old child. Worked for father-in-law and ran business in his absence.

ATTITUDES: Has set goals very high. Wants prestige and high salary of important position. Does not feel that retail business offers this. Is not sure what he can do or wants to do. Feels it is imperative that he maintain wife at level to which she is accustomed. At the same time, he feels he can not afford to spend time in exploration, education, or apprenticeship. Feels inferior because of educational status--friends are all college graduates as is his wife. Says he fears it will be "thrown in his face" if he seeks employment, but at same time he rationalizes that college isn't essential and has mainly prestige and contact-making value. Father-in-law wants and expects him to enter business. However, patient reacts strongly against this. States he doesn't want to be indebted to him or dependent on him. Wife's attitude is strictly hands-off--does not argue in favor of anything--wants him to make decision and will approve of any outcome. Patient seems to feel that this adds to his problem as he doesn't know where he stands. States that the extrinsic aspects of success have always meant most--has never had occasion to really lose self in any interest. States he is interested in everything and can discuss intelligently nearly everything.

Davis, Case #1941

2nd Interview:

Patient continued to develop theme of family relationships. States father-in-law is a domineering and suspicious person and is never willing to delegate any responsibility or authority. There is constant conflict with the employees and the father-in-law is disliked by other business men. The patient's wife is close to her father although they argue continually. She is the only one her father will listen to, and she has assumed much of the responsibility of the store. The patient states he feels out of the picture--they tend to ignore him on most counts. He feels that he could never go into the family business because if he did there would be a continual battle between himself and the rest of the family.

At the same time, he rejects any idea of schooling or training at a poor salary. He feels that his in-laws already regard him as a liability and not too promising. He continues to emphasize his resentment at the prestige carried by a college degree and his own feelings of insecurity in this respect. He speaks vaguely of entering commercial aviation but his interests and ambitions center around a business career.

Prior to his marriage, the patient, apparently, was fairly well satisfied with his prospects and was regarded by his family as showing unusual promise in the business field. Because of his father's failure in this field, success in it has become of paramount importance to him,

and now that he is in direct competition with his wife and her family in this field, and in that they have achieved more than himself, thus jeopardizing his status both in and out of the family, he has tended to raise his criterion of success much higher.

Toward the end of the interview, the patient re-phrased his problem in similar terms, stating that he realized now that he was not seeking vocational advice as he was pretty definitely set on entering some phase of business activity, preferably in the retail trade. He said that he had known all along that it was family trouble that upset him but that he was so mixed up he couldn't think it through.

Davis, Case #1941

3rd Interview:

The patient began formulating his goals in objective terms. He said he realized that a retail business is hazardous and that at best, a substantial income could not be expected for a number of years. "I've been feeling that I had to do the miraculous." He feels that Miami offers him the best opportunities and the most contacts, and he has made up his mind to break away from his father-in-law regardless of the economic consequences.

Alternatives were canvassed including his personal contacts with people in larger concerns and related work. He feels that the independence of his own store is not essential to him and that he would be equally satisfied working with others. It is apparent to him that he must approach the question of type of business or position more objectively than he has done so far.

The patient is eligible for discharge but is undecided as he feels he is not ready to make his decisions. It was suggested to him that as a returnee, he might be able to obtain an assignment in Miami so as to have time to explore the problem further while still retaining the security of the army.

Follow-up (Week later)

Patient has secured promise of assignment in Miami District through Redistribution Station. He has contacted several acquaintances and is optimistic about possibilities of attaining employment as a company representative or export agent. His family status is the same but he has more confidence of solving it once he gets on his own. The past few days he has visited the Chamber of Commerce for data on Miami and post war, and has been discussing retail possibilities.

PROGRAM PLACEMENT AND PSYCHOLOGICAL BRANCH
UNIT T

NAME: Savage, John D. Case 2673 WARD: 27 MEDICAL OFFICER: Capt. Rylands

INTERVIEWER: Lt. Lawrence DIAGNOSIS: Anxiety DATE: 29 May 1945

AGE: 24 GRADE: Capt.
O.S.: 6 mos. THEATRE: ETO
A.F.: 8th DUTY: Post Adjutant

COMPLAINT: After an operation for sinus trouble, the patient began to develop severe frontal headaches and to lose weight. At the same time he lost interest in other activities and found he needed an excessive amount of sleep, often 18 to 20 hours at a time. States that they had to give him stimulants to keep him awake. The patient consulted a psychiatrist about his condition but refused to accept any statement of a connection between his symptoms and his personal problems. "I won't be classified as a psychoneurotic."

ARMY BACKGROUND: The patient volunteered for one year's military training in August of 1941 in order to "get away from conditions at home". Upon the outbreak of war he was retained in the army and soon became Personnel Sergeant Major and later Base Sergeant Major. He complained that he found little satisfaction in the army because he was ordered about and dominated by the army just as he had been at home, nor could he find individuals to associate with who had interests comparable to his own. Finally an officer whom he had known at home and had despised was put over him. The patient describes the officer as an "ignorant athlete who got his commission merely because he had taken ROTC in college". As a consequence the patient was motivated to attend Air Corps OCS, passed with excellent grades, was sent to Administrative School, and then assigned as post adjutant in the ATC in Pennsylvania. For thirteen months he was quite satisfied with this assignment, having formed a close relationship with a flight surgeon there. They roomed together, had the same interests and tastes, and spent much of their spare time playing bridge and attending movies. He states that his friend was "one of the few men I have ever looked up to and admired", and expressed some contempt for other officers "spending their time on drinking and women". About this time he developed some symptoms of sinusitis. His friend was shipped overseas and after that he experienced some depression. The patient was sent to England in August 1944 and shortly after his arrival began to have considerable trouble with facial pains and nasal drip. He was hospitalized three out of five months overseas. Upon being returned to the states, he was operated on and his sinus opened; he describes the operation as a "terrible mental strain".

"Sometimes I would actually see my mother standing beside the bed and reach out for her. They had to keep me doped continually." Since that time, despite freedom from sinus symptoms, he has frequent headaches, has lost twenty pounds, and sleeps excessively. At the present time, he states that he is quite fed up with the Army as it didn't give him the "escape" he wanted, but that he is resigned to staying in as long as he can get back into the ATC.

PERSONAL BACKGROUND: This 24 year old patient is the younger of two sons. The father owns a chain of hardware stores and is described as an active, practical and domineering "motor" type. The mother is described as "more like myself", somewhat nervous, temperamental, and interested in social activities. The older brother takes after the father in interests and personality. At present he is in the Army, has been through extensive combat in the Southwest Pacific, and is hoping to get out of the Army and into the father's business. The patient states that his home life was never congenial. The older brother and the father associated constantly in sports and the like while he was left at home to take care of his mother. When he was in the 7th grade, he rarely saw his father because of business trips and shortly thereafter his mother began to leave on extended visits. As a result, he was left at home with only the servants. As a consequence, he says that he developed strong interests in reading and studying, made straight A's in school, and although he had a car and anything else he wanted he had little interest in the usual social activities. About this time he studied art, did well, and was offered a fellowship by an academy. However, his father refused to hear of it and insisted on his going to college. The patient states that his father was always dominating him. "I blame him because he was always negligent toward me yet he decided everything I did. I have a lot of affection for my mother but I hate my father." He was also in conflict with his brother. "He was my father's favorite. We don't even look alike, let alone think alike." He attended college for two years in Business Administration but had no interest in it. He spent his time playing bridge and dancing. "The usual social functions just bored me." He had hoped that getting away from home would help but he felt he was just drifting and was unable to find the enjoyment he expects. Consequently, he joined the Army to make the break more complete. His parents were bitterly opposed but since his commissioning they have come to respect him more. At present he has two problems. He is totally undecided as to what to do after getting out of the Army. "I could never do the sort of thing that interests my father and brother." He talks of becoming a private secretary to "some big man". He has sought help in making a decision but has rejected this advice each time. His other concern is with marriage. He claims that his parents are trying to force him into marriage with a family friend. "She is just like myself--always dominated at home and wants to get away. She is the only girl whose company I really enjoy. We used to go window shopping and I enjoyed it more than dates with the others who are only interested in how much you spend."

The patient hopes to get a leave to see her and to make up his mind about the marriage.

SUMMARY: The patient appears to be quite immature emotionally and to have had a fairly strong dependence on the mother. His relationship to his father and brother was one of conflict and subordination. Apparently invidious comparisons were made between the children. As a consequence he withdrew and found some compensation in excelling at studies, bridge, art, dancing, and the like. His social relations have always been unsatisfying except for some close relation with older men. He had hoped to escape by joining the army but found little satisfaction. At present he is being forced into making decisions about marriage and occupation.

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PROGRAM PLACEMENT AND PSYCHOLOGICAL BRANCH
UNIT T

NAME: Tobler, Edward A. Case #1997 WARD: 32 SURGEON: Major Shephard

INTERVIEWER: Lt. Thomas DIAGNOSIS; Surgical DATE: 17 April 1945

GRADE: Pvt. AGE: 29

COMPLAINT: Was operated on for hernia and has been feeling worse since the operation. Had trouble voiding until yesterday (16 April) but thinks this trouble has cleared. Evidence during interview of depression and feeling of bitterness toward army. Some flight of ideas and loss of memory. Can't sleep nights and complains of high skin color some mornings and pallor on others. Also complains of pains in heart and persistent trembling. Head aches frequently.

ARMY EXPERIENCE: Inducted January 1943 in Medical Corps but was transferred to AC. Doesn't know why. Spent 30 days under guard because of assualt with intent to kill. AWOL for 2 days later on.

PERSONAL BACKGROUND: Sometime before induction into Army (couldn't remember how long) he was in a fight over an insult to his wife. During the fight he was hit on the head with a rock and "everything went black". When his senses cleared he found himself stabbing at his assailant with a knife. Again, shortly after his basic training, the patient became involved with 5 Mexicans stationed at the same post over a remark in a tavern against Tennessee, and again "things went black" and he used a knife. Someone hit him in the head with a bottle and he was unconscious for a short time.

In November 1944 he heard his wife was unfaithful and obtained a 7 day leave to go home. Says she was ashamed to face him and they decided on a divorce. Believes her infidelity was due to her inability to bear children (3 miscomceptions) and a later ovarian operation.

A few months ago (could not remember the exact time) he asked for a furlough. When it was denied he went AWOL because he felt the army unjust. Returned two days later, was restricted for one week, and then (apparently) was assigned to the Biltmore for parmanent K.P. Was taking sulpha pills there for infected tonsil and developed a rash. Went on sick call and at the same time asked for medical attention for hernia. Is sorry now he ever mentioned it since he feels much worse than he did before the operation.

While at Robbins Field he became dizzy during drill one day and ever since has been troubled with pains near heart, breaking out in cold sweat and trembling of hands and eyelids. At that time he was sent to consult the field psychiatrist "but told the psychiatrist he was not crazy", and was allowed to go back to duty.

Has a younger sister and two younger brothers. The sister bore a child out of wedlock by a soldier later killed in Italy. Sister has since developed some affliction in chest--"maybe TB". Father is a miner but has not worked for past few years because of "miner's asthma". Mother is also sickly.

Patient passed 5th grade at the age of 17, then quit school to work in mines.

During interview patient was cooperative and seemed anxious to talk, but had to be asked to repeat many statements because of tendency to mumble rather than speak clearly. Had difficulty remembering dates and putting events of the past few years in their proper sequences. Also had difficulty sticking to one subject (flight of ideas).

Feels very bitter against the army and "hates his wife because she is running around with anything she can get". Says he wants to "get married and have children" if he finds the right girl but at present does not have much interest in women although he has had frequent sexual relations recently. Resents attitude of medical officers toward his ailments and feels that he is not recuperating from the operation as rapidly as he should.

RECOMMENDATIONS: It is the feeling of the interviewer that this man may be a border line psychiatric case but that psychiatric aid is not at this time essential. Possibly, more individual attention by a physician would tend to relieve the patient's anxiety over his condition. He probably should be kept under rather close observation for sometime.

EVALUATION AND PROGRAM PLACEMENT FUNCTIONS, UNIT B

I The Installation

The Biltmore Unit of the AAFRCH is located in Coral Gables, Florida, some seventeen miles from Headquarters and the other hospitals in the District at Miami Beach. The hospital occupies the plant and grounds of the Miami Biltmore, formerly a famous luxury hotel. The present plant includes a large twelve-story building which houses the majority of the wards, laboratories and administrative offices; a two story building devoted to the wards, offices and recreational facilities of the Psychiatric Services Division; a two story building housing Red Cross, the office of the Physical Training Department, various administrative offices and the combined offices of the Convalescent Services Division and the Psychological Branch; and a two story building containing the Orthopedic Convalescent wards and the Convalescent Services Division shops. The grounds include two swimming pools, several tennis courts and an eighteen hole golf course.

II Function of the Hospital

Unlike the Beach installations, Unit B is more a general hospital than a convalescent hospital. It has a bed capacity of 1345 patients divided among twenty-six wards; eight surgical, five medical, eleven psychiatric and two orthopedic convalescent. Three groups of patients are serviced. The largest group includespatients receiving departure treatment for combat-converted disabilities. A smaller group consists of air evacuees awaiting transportation to general hsopitals. A third group includes a small number of patients of the type to be found in any station hospital. There is no group officially designated convalescent, and patients participating in the program of the Convalescent Services Division come from all three of the above groups.

III The Convalescent Services Division

Functioning under the name of the Rehabilitation Department, the division had, for approximately two years prior to the Biltmore's designation as a Unit of AAFRCH, carried on a convalescent program for its patients. The facilities of this Division include wood-working, metal-working and plastics shops, a photo laboratory, a fine arts studio, a synthetic trainer room, a hydroponics laboratory, an ordnance shop and equipment for teaching commercial subjects. The administration of the entire convalescent program rests with this division. In its program-placement function, the Psychological Branch works in close cooperation with other Convalescent Services Branches.

IV The Psychological Branch

At Unit B, the Psychological Branch is divided into two sections: the Evaluation and Program Placement Section, which interviews patients and assigns them to convalescent activities; and the Testing Section, which administers psychological tests to patients referred by the Psychiatric Service or by other medical services, and to others coming for vocational or educational guidance. The Branch offices at Unit B consist of one half of a large room in a building next to the main building, (shared with Convalescent Services), two smaller adjoining rooms, and a small room in the Psychiatric Wing. Desks in the large room accomodate all Branch personnel, the three smaller rooms being used for testing and case conferences. Only the former is described in this section.

A. Procedures: The Program Placement Section initiated operations at Unit B on 7 March 1945. The personnel at that time included one officer and two enlisted men. On 9 March, in an effort to get as many men as possible into the program quickly, two meetings were called for all officer patients designated as convalescent by their ward officers. The meetings were addressed by the Chief of the Convalescent Services Division and by the Assistant OIC of this Branch for Unit B, who explained the aims of the program and described the facilities available. At the close of the meetings, the patients were briefly and informally interviewed and assigned to activities of their preferance. The assignment was made on the basis of a five hour program, two hours of which were devoted to Physical Training.

Some one hundred patients were thus assigned to the program. Previously the patients' time was their own and, consequently, resistance to the program was great. Subsequent investigation revealed that the greater percentage of the men signed up for the program at the close of the meetings did not participate in any activity.

As patients at Unit B are not routinely designated as convalescent, it was felt that every new patient coming into the Biltmore should be seen, to determine whether he could participate in the program. Lists of the new patients were made daily from the Hospital Admission and Disposition roster and an enlisted man visited each new patient, talked with him informally, consulted his ward officer or nurse when necessary. If the patient was found physically qualified for the program he was asked to report to Program Placement for an interview. When the patient appeared he was welcomed briefly by the OIC and was then interviewed and placed in the program. Evaluative write-ups similar to those at Unit "T" were done for each patient interviewed.

The afore-described procedure soon proved unfeasable. Many patients were missed because they were not in the wards when the representative of the Branch made his rounds and many patients scheduled for

formal interviews did not appear. Many man hours were being consumed by the ward rounds and too few patients were being absorbed by the program.

It was then felt that the administrative aspects of the program should be reorganized to include more prominently the ward officers under whose direct supervision all phases of the patient's hospital life were carried on. The Assistant OIC for Unit B conferred informally with the various ward officers concerned and a system was evolved in which the ward officers designated the patients they felt should be included in the Convalescent Program and sent those patients to the Branch office. With the patient was sent an individual prescription form on which the ward officer specified types of activity in which the patient could participate. This system has proved to be satisfactory and is in use at the present time, supplemented by personal contacts in the wards, in the shops, and at an information desk in the main lobby. Due to the increased office load consequent to the revision of the system, an additional enlisted Psychologist was assigned to Unit B on 23 April 1945.

As at Unit T, the Psychological Branch at Unit B attempted to conduct a convalescent forum or orientation program. Early in its history, the Branch set up a series of lectures and discussion periods dealing with adjustment problems in general and those of the convalescent serviceman in particular. Attendance at these sessions proved particularly poor and they have been discontinued. Failure was apparently due to the fact that Unit B is primarily a definitive hospital, and that it is consequently difficult to get the few so-called convalescent patients to conform to convalescent routines.

Personal, vocational and educational guidance is undertaken by the Branch upon recommendation of the patient's ward officer or at the request of the patient.

As has been indicated, the Evaluation and Program Placement functions at Unit B have undergone continuous revision since their institution. It has been impossible to follow, with any success, the general procedures developed at Unit T and prescribed in directives, because of the size and the varied functions of the Biltmore hospital. Four factors inherent in the organization of the hospital have handicapped the program:

1. There are no patients at Unit B designated as convalescent, thus eligibility of a patient for the program is difficult to determine. (Enrolment in convalescent activities averages about 150 out of approximately 1000 patients).

2. All patients are undergoing definitive treatment. Ward rounds, special treatment and consultations interrupt the patient's activity schedule.

3. A great number of Unit B patients are not recommended for the program and they may do as they please throughout the day. They are eligible for early passes, etc. This has a demoralizing effect upon the men in the program.

4. Patients able to participate in convalescent activities stay just a short time, since there is constant pressure to make beds available for definitive patients.

At the present time a concerted effort is being made to "sell" the program to as many individual patients as possible and to adjust the activities to the decreasing average length of stay. A representative of the Branch is stationed in the shop area and another in the main lobby at busy times to answer questions and to help those patients who come to look at the facilities of their own accord. The Convalescent Services Division has organized an effective publicity program and their efforts have produced gratifying results. Psychologists are working more closely with ward officers in making contacts with patients, in taking case histories (evaluation interviewing), and in program placement. In view of the definitive nature of the hospital treatment, placement in convalescent activities is done on a highly individualized basis, both as to type of activity and time in activities.

B. Illustrations of Psychological Placement: The following three cases represent instances where in the course of program placement, the activities of the patients were theraputic in nature.

1. In the first instance, a captain who had accomplished 33 combat missions presented a badly smashed left hand. The fingers were stiff and seemed relatively useless. His own choice for an activity was photography and he managed better than he had expected. In the meantime, it was known that he had once played the piano and retained an interest in music. During subsequent contacts the psychologist suggested that he resume his piano playing. The captain, loathe to create disharmonies, was skeptical, but finally he did realize that his ear for music might be sacrificed for the sake of his hand. In the course of several weeks of steady practice he now offends his musical sensitivity less and less as the stiffened, shattered fingers develop more and more dexterity. From the music and the improvement of his hand he has obtained increased satisfaction. His progress has been noted and the music instructor, aware of the problem, has participated actively in the treatment.

2. A second instance of psychological placement occurred with a lieutenant, three days ambulant, after months of being bed-ridden with undulant fever. Physically this man was weak to the extent of walking with a shuffle; he had lost

fifty pounds. Mentally, too, he seemed to shuffle. Thinking and speech gave the impression of being slowed down and uncertain. He was doubtful about his ability to do anything, but his attitude was positive. Leather work was suggested to him since he could work either sitting or standing at a table. The instructor was advised in advance of the lieutenant's attendance and given an idea of his condition so that he would receive some special help and encouragement at first. Although the instructor was at first reluctant to take on a patient for leather work, as there was no instruction in that subject, the patient-conscious psychologist helped him see the necessity of giving the patient a chance to do something suited to his needs. Beginning with this sedentary activity, the patient found real satisfaction in following the manual and making a leather wallet. When this was finished, he was ready for more strenuous activities.

3. The third instance of follow-through from an initial casual contact occurred with a concert pianist, who after sixteen months overseas and a subsequent failure on a domestic assignment had to be hospitalized for an emotional disturbance. The first contact developed as an official one through the ward physician who urged the patient to work with the Program Placement representative. At this stage, however, the patient was loathe to leave his room, made appointments and then failed to keep them. He believed he would not be able to play, or if he could the results would be hopeless. The music instructor was consulted at this point and asked to visit the patient. The patient was induced to visit the music room where he listened to some records, but refused to touch the piano. To help him revive his musical interests he was asked to help select some records for the department. Finally he did play, but only when completely alone. Later he was able to accept the presence of a few listeners. When transferred he was planning a concert for patients in the hospital. Throughout the period of his hospitalization there was steady albeit slow progress in the field of music, attended by widening range of other interests and activities and by increasing self-confidence.

These three cases illustrate that, in numerous instances, the Program Placement work of psychologists is not completed simply by interviewing the patient, but that a continuing interest in him is desirable and helpful by way of hastening his recovery, and that some of it is most effectively done in the wards, shops, and patient gathering places.

EVALUATION AND PROGRAM PLACEMENT FUNCTIONS, UNIT N

As Unit N is a definitive hospital with severe operational fatigue and surgical patients, no attempt has been made to develop a full-fledged psychological program there. Instead, services have been provided as requested by the various divisions. So far, only Program Placement has been requested by the Convalescent Services Division. The chief psychiatrist at Unit N being averse to utilizing psychological services, no history taking is done. One psychiatrist occasionally refers patients to Unit T for testing.

Preparations for the Convalescent Training Program at the Nautilus Unit began with the mass enrollment of qualified patients on 26 Jan 1945. Two enlisted men from Unit T kept office hours in the afternoon, making the trip each day from the Tower. One man gave as many as three orientation talks in an afternoon, and men were interviewed and assigned to classes, shops, and sports.

Class work began at Unit N on 1 February,and shortly thereafter one enlisted psychological assistant was sent there on a full-time basis; since then he has carried on the program placement work with the occasional assistance of another man from Unit T, under the general supervision of the Assistant OIC at Unit T.

Under the present system, the Ward Officer sends a Qualification Sheet to the Plans and Schedules Section when a patient is ready for the program. He is then scheduled for orientation and an initial interview. The Psychological Assistant gives a 30 minute orientation talk at 0930 each morning and then sees each man individually for about 15 minutes. The load has averaged five per day during the past four weeks. During this interview, a program for the man is worked out. All activity changes are handled by the Psychological Assistant, and these have been averaging three per day during the last four-week period. About 150 patients are now enrolled in the program at Unit N and more than 500 patients have been processed.

Because there is no Special Service or Personal Affairs Office at Unit N, this Branch assists patients with USAFI enrollments and with referrals to the proper office for bond, allotment, pay, insurances, and legal difficulties.

The work at Unit N is done under a sign labeled "Initial Interview Section", at a desk in one corner of the first floor lobby. Talks are given in competition with piano movers, floor waxers, over-exuberant guests, and sport-clothed blondes. Despite these drawbacks, follow-ups of numerous patients indicate that worthwhile results are being obtained.

GUIDE FOR CASE HISTORY TAKING

A. Army Experiences
   1. Date joined; time in U.S.; time O.S.; theater
   2. Enlisted or inducted; if enlisted, reasons
   3. Parents' attitude toward his service; wife's attitude
   4. Deferments; number obtained and reasons; number requested and reasons
   5. Service schools attended; standing in class and satisfaction in work
   6. Applications for O.C.S., cadets, special training; if rejected, reasons
      a. If cadet, choice PBN; if wash-out pilot or cadet, his reason and result; present desire for retraining
   7. Duty assignments and satisfaction in duty
   8. Sick call and hospitalization; frequency and reasons
   9. Record of AWOL, court martials, company punishment, discipline
   10. Combat experiences
      a. Crew duties, number of hours, missions, etc.
      b. Crew bombed, crashed, bailed out, ditched, etc.; circumstances and his reaction to it
      c. Crew witness deaths, wounding, crashes, etc. of others; reaction to it
      d. Nervous symptoms; when began, severity, and duration
         (1) sleep, dreams, eating habits, weight loss, tremors, bowels
         (2) irritability, inability to concentrate, relation to others
      e. Personal relationships; conflict with crew members, superiors, and attitude toward organization and operations
      f. Ever grounded or put in rest camp and reasons; medical treatment and extent
   11. Recreational facilities and habits in camp; leaves given
   12. Duty beyond tour; type, extent, and reason
   13. Present attitude toward flying and duty in army

B. Family Background
   1. Patient's birthplace, date, and frequency of moves and reason
      a. If foreign born, when came to U.S., age, and its effect on his adjustment to his group; reaction of others and his own reaction
   2. Parents' birthplace
      a. If foreign born, when came to U.S., age, degree of assimilation, and its influence on their economic and social status, patient's reaction
   3. Presence of parents in home
      a. Both living (yes or no) and present health
         (1) if one dead; which one, cause, age of patient at time, who took place of deceased, and patient's reaction to death

b. Marital status of parents; married, separated, divorced
   (1) If divorced: reason, age of patient, patient with which one, one most to blame according to patient, and patient's reaction
   (2) If still married
      (a) ever separated and reason, age of patient, patient with which one, who most to blame
      (b) closeness of relationship of parents, patient's reaction to quarrels
   (3) Mother's absence from home; reason, frequency, and effect on patient
   (4) Father's absence from home; reason, frequency, and effect on patient

C. Development History
1. Separation from home as a child
   a. If yes; reasons, age, length of time, stayed with whom, treatment, patient's reaction
2. Competition with siblings
   a. Number of older brothers, older sisters, younger brothers, younger sisters
   b. Who was regarded as most social, smartest, most popular, etc.
   c. Who has achieved most in social and economic status; patient's reaction
   d. Degree of association and conflict between siblings
   e. Mother's favorite, father's favorite
3. Parent's attitude toward patient as child
   a. How much did they play with child, manner, and patient's reaction
   b. Criticism of child as slow, unintelligent, bad, unattractive, quiet, noisy, and manner in which done
   c. Disciplined by whom, why, how, frequency, patient's reaction, and consistency of discipline
   d. Supervision by parents: strictness, in what things, degree of enforcement, patient's reaction
4. Patient's relations to others as child:
   a. Play habits: type of games and amusements
      (1) If alone, reason and patient's reaction
      (2) If with others, older or younger, status in group, type of group, quarrels and reason, feeling of belongingness
   b. Contact with and reaction to older people and company
   c. Neighbors' attitude toward patient as mischief maker, playmate, etc.
5. Appearance and handicaps as child
   a. Nickname, reasons for it, patient's reaction
   b. Physical appearance (fat, skinny, etc.), comments made about it, reaction toward it
   c. Defects (stuttering, eye trouble, etc.), comments made about it, reaction of others and self

d. Sickness: kind, extent, and effect on activities
e. Fears and behavior difficulties, kind and parents' reaction

D. Economic Condition of Home
1. Parents' occupational level, stability of employment, and reason for instability
2. Adequacy and courses of income and effect of depression
   a. Effect on clothes, housing, food, education, amusement, etc., of home
   b. Comparison with effect on friends, neighbors, feelings of shame or frustration engendered
3. Occupational mobility of family: parents' satisfaction with status, degree of security achieved, and occupational ambitions for children

E. Education of Patient
1. Age begun, first reactions, early humiliations and successes
2. Behavior in classroom and playground
3. Truancy and absenteeism, reason and result
4. Failures, expulsions, and disciplining: cause and effect
5. Satisfaction in school: sources, grades achieved, recognition given
6. When did he quit school, grade, reason
7. Parent's attitude toward amount and type of education and patient's actual achievement.
8. Future plans and present attitude toward school

F. Patient's Occupational History
1. While in school: jobs held, disposition of earnings, effect on social and recreational activities, reason quit, patient's reaction to jobs
2. After leaving school: jobs held, income, reason for leaving, satisfaction in work
3. Future plans: type and level of occupation, reasons for choice, steps taken, confidence in choice, and outcome
4. Financial obligations now and in future: patient's, siblings, wife or fiancee, children, and attitude toward obligations

G. Social Relations
1. Minority status (color, foreign, religion)
   a. Extent of friends in majority group, on what basis, degree of acceptance
   b. Discrimination experience, reaction, and attitude toward majority
2. Activities and hobbies (chores, sports, reading); reason and attitude of parents
3. Membership in gang, activities, position in it, degree of acceptance
4. Membership in clubs and societies, type and those rejecting him

5. Sports: degree and type of participation, aspirations in school, achievement and satisfaction
6. Dating: when begun, frequency, satisfaction, parents' attitude
7. Sexual relations: first, frequency, satisfaction
8. Marital status
   a. If married: how long, length of courtship, attitude of parents, number of children, and whether wanted or unwanted, influence of war on relationship
   b. If single: engagements and reasons for breaking; ever rejected and reason; future plans
9. Recreations (drinking, reading, etc.), extent, reasons, satisfaction

STATISTICAL SUMMARY
EVALUATION FUNCTIONS
TABLE XIV

I. Initial Evaluations:

A. Number Interviewed
B. Interview Hours
C. Tests Administered

II. Supplementary Evaluations:

A. Number Interviewed
B. Interview Hours
C. Tests Administered:

1. DE 301C Rorschach Technique, Free Response
2. DE 302A Thematic Apperception Test
3. DE 601A Shipley-Hartford Test
4. DE 603A Hunt-Minnesota Test
5. DG 902A Wechsler-Bellevue Test, Form A
6. DG 903A Army Individual Test
7. Stanford-Binet Test (1936)
8. Bellevue-Memory
9. Continuous Addition Test
10. Wells Aphasia Test
11. Aphasia Battery
12. Kent Emergency Test

III. Terminal Evaluations:

A. Number Interviewed
B. Interview Hours
C. Tests Administered

TABLE XIV (CONT)

		28 Oct. to 2 Dec.			3 Dec. to 9 Dec.		
I.		O	E	T	O	E	T
	A.	45	255	300	11	40	51
	B.	30	197	227	6	22	28
	C.						
II.							
	A.	5	10	15		2	2
	B.	6	11	17		1	1
	C.						
	1		1	1			
	5		8	8		4	4
III.							
	A.					1	1
	B.					½	½
	C.						

		10 Dec. to 16 Dec.			17 Dec. to 23 Dec.			24 Dec. to 30 Dec.		
I.		O	E	T	O	E	T	O	E	T
	A.	18	22	40	5	22	27	3	41	44
	B.	10	11	21	6	15	21	2	31	33
	C.									
II.										
	A.	2	20	22	2	6	8	4	8	12
	B.	1	9	10	1	3	4	2	4	6
	C.									
	2								1	1
	5		3	3						
	6					2	2		1	1
III.										
	A.	1	13	14	6	14	20	3	3	6
	B.	½	5	5½	2	5	7	1	1	2
	C.									

TABLE XIV (CONT)

		31 Dec. to 6 Jan.			7 Jan. to 13 Jan.			14 Jan. to 20 Jan.		
		O	E	T	O	E	T	O	E	T
I.										
	A.	7	34	41	17	83	100	13	51	64
	B.	6	20	26	10	37	47	6	22	28
	C.									
II.										
	A.	1	7	8		5	5	1	10	11
	B.	1	4	5		2	2	1	4	5
	C.									
	5								2	2
	6								1	1
III.										
	A.	4	7	11	6	1	7	7	55	62
	B.	2	3	5	3	1	4	3	15	18
	C.									

		21 Jan. to 27 Jan.			28 Jan. to 3 Feb.			4 Feb. to 10 Feb.		
		O	E	T	O	E	T	O	E	T
I.										
	A.	17	56	73	20	91	111	23	111	134
	B.	9	25	34	10	35	45	11	50	61
	C.									
II.										
	A.	4	6	10		8	8		5	5
	B.	2	3	5		3	3		2	2
	C.									
	1					1	1		1	1
	2								1	1
	5		1	1		1	1			
III.										
	A.	5	30	35	4	33	37	4	29	33
	B.	2	8	10	1	9	10	2	9	11
	C.									

TABLE XIV (CONT)

		11 Feb. to 17 Feb.			18 Feb. to 24 Feb.			25 Feb. to 3 Mar.		
		O	E	T	O	E	T	O	E	T
I.										
	A.	22	135	157	27	104	131	16	93	109
	B.	11	48	59	14	52	66	8	36	44
	C.									
II.										
	A.		5	5	2	5	7	2	10	12
	B.		3	3	2	3	5	1	4	5
	C.									
	1					1	1		1	1
	5		2	2		1	1			
III.										
	A.	8	46	54	8	53	61	15	53	68
	B.	2	12	14	2	13	15	4	13	17
	C.									

		4 Mar. to 10 Mar.			11 Mar. to 17 Mar.			18 Mar. to 24 Mar.		
		O	E	T	O	E	T	O	E	T
I.										
	A.	22	137	159	98	82	180	38	78	116
	B.	11	69	80	49	41	90	10	27	37
	C.									
II.										
	A.		17	17		14	14		22	22
	B.		8	8		7	7		9	9
	C.									
	1								3	3
	5								2	2
III.										
	A.	14	24	38	17	37	54	11	23	34
	B.	4	6	10	5	10	15	2	7	9
	C.									

TABLE XIV (CONT)

		25 Mar. to 31 Mar.			1 Apr. to 7 Apr.			8 Apr. to 14 Apr.		
		O	E	T	O	E	T	O	E	T
I.										
	A.	20	36	56	11	73	84	17	46	63
	B.	10	18	28	5	27	32	8½	23	31½
	C.									
II.										
	A.	6	18	24	1	29	30	10	18	28
	B.	6½	20½	27	1	18	19	9	12	21
	C.									
	1	2	5	7	1	9	10	2	2	4
	2	1	1	2						
	5	2	2	4		5	5	2	2	4
	8		1	1				2	1	3
	10							1		1
	12					1	1			
III.										
	A.	6	15	21	11	23	34	7	16	23
	B.	1½	3½	5	2	7	9	2	5	7
	C.									

		15 Apr. to 21 Apr.			22 Apr. to 28 Apr.			29 Apr. to 5 May		
		O	E	T	O	E	T	O	E	T
I.										
	A.	16	37	53	24	61	85	35	85	120
	B.	8	18½	26½	17½	26	43½	20½	53	73½
	C.									
II.										
	A.	8	27	35	11	27	38	17	32	49
	B.	4	32	36	7	29	36	28	24	52
	C.									
	1		5	5	1	6	7	5	2	7
	2							1		1
	5		6	6	1	6	7	6	4	10
	8				1	1	2	2		2
	9				1	2	3	2		2
III.										
	A.	14	12	26	10	39	49	11	36	47
	B.	3½	3	6½	5	19½	24½	3	9	12
	C.									

TABLE XIV (CONT)

	6 May to 12 May			13 May to 19 May			20 May to 26 May		
	O	E	T	O	E	T	O	E	T
I.									
A.	26	105	131	23	101	124	19	76	95
B.	16	56	72	20	59	79	13½	45	58½
C.									
II.									
A.	5	48	53	8	42	50	8	39	47
B.	15	41	56	17	49	66	11	41½	52½
C.									
1	2	7	9	2	4	6	3	6	9
2	1		1		2	2	1	1	2
3								1	1
4								1	1
5	2	6	8	2	6	8	1	6	7
8	2		2		4	4		1	1
9	1		1		1	1			
11								1	1
III.									
A.	21	27	48	24	40	64	12	34	46
B.	6	7	13	7	11	18	3½	8½	12
C.									

TABLE XIV (CONT)

		27 May to 2 June			3 June to 9 June			10 June to 16 June		
		O	E	T	O	E	T	O	E	T
I.										
	A.	14	69	83	12	87	99	7	87	94
	B.	9	36	45	10	53½	63½	5½	55	60½
	C.									
II.										
	A.	7	28	35	4	55	59	13	29	42
	B.	16	38	54	2½	66	68½	27½	22	49½
	C.									
	1	1	3	4		9	9	4	3	7
	2	1	2	3		1	1			
	3	1	2	3		5	5	3	1	4
	4	1	2	3		5	5	2	2	4
	5	4	7	11	1	11	12	6	1	7
	7								1	1
	8					1	1			
	9		1	1						
III.										
	A.	12	31	43	4	30	34	8	18	26
	B.	5	12	17	2	15	17	4	9	13
	C.									

TABLE XIV (CONT)

		17 June to 23 June			24 June to 30 June		
		O	E	T	O	E	T
I.							
	A.	12	52	64	11	36	47
	B.	11	26	37	9	17	26
	C.						
II.							
	A.	8	39	47	8	36	44
	B.	17½	56	73½	24	34	58
	C.						
	1	3	8	11	6	3	9
	2	1	3	4	5	1	6
	3	2	3	5		1	1
	4	2	2	4		3	3
	5	2	7	9			
	6		1	1			
	9					1	1
III.							
	A.	5	19	24	7	21	28
	B.	2½	9½	12	4	13	17
	C.						

STATISTICAL SUMMARY
EVALUATION FUNCTIONS
TOTALS
TABLE XV

		Officers	EM	Total
I.	Initial Evaluations			
	A. Number Interviewed	649	2386	3035
	B. Interview Hours	372½	1251	1623½
II.	Supplementary Evaluations			
	A. Number Interviewed	137	627	764
	B. Interview Hours	203	563	766
	C. Tests Administered	95	235	330
	1. DE 301C Rorschach Technique, Free Response	32	79	111
	2. DE 302A Thematic Apperception Test	11	13	24
	3. DE 601A Shipley-Hartford Test	6	13	19
	4. DE 603A Hunt-Minnesota Test	5	15	20
	5. DG 902A Wechsler-Bellevue Test, Form A	29	93	122
	6. DG 903A Army Individual Test	0	5	5
	7. Stanford-Binet Test (1936)	0	1	1
	8. Bellevue-Memory	7	9	16
	9. Continuous Addition Test	4	5	9
	10. Wells Aphasia Test	1	0	1
	11. Aphasia Battery	0	1	1
	12. Kent Emergency Test	0	1	1
III.	Terminal Evaluations			
	A. Number Interviewed	265	783	1048
	B. Interview Hours	86½	249½	336

TESTING FOR VOCATIONAL COUNSELING

G E D TESTING

TESTING FUNCTIONS

The Testing Section began functioning at Unit T on 9 October 1944 in rather inadequate offices in the Gulfstream Hotel. The two enlisted men then assigned performed the Branch functions of interviewing and testing. Testing materials were not yet issued to the Branch, and a quickly constructed interest questionnaire and the Thurstone Interest Inventory were used as aids in the Program Placement function. Hospital funds were made available to purchase testing materials immediately needed. The list of required tests was made from a study of sample copies of standard tests furnished by the University of Miami. On 14 October 1944 the Separations Program was organized and the Testing Section began administering aptitude tests for use in vocational guidance. In all, approximately 70 men were processed by the Branch in October, and about one-third of this number were tested.

When the Branch moved to Cottage #5 on 15 November 1944, the Section was given one small room. After the move to Cottages #7 and #8, the Testing Section functioned in a large room in Cottage #7 in order to be adjacent to the Separations Program which used its services almost exclusively. At this time the Section was manned by one officer and 4 enlisted men. The psychological examiners were to administer, score, and interpret tests for:

I. Vocational counseling, to determine aptitudes, achievement, and interest for further educational or vocational choices.

II. Psychiatric referrals, e.g., the Wechsler-Bellevue Adult Scale, the Army Individual Test, and personality tests such as the Rorschach and the Thematic-Apperception Test.

III. Program Placement, to determine attitudes, aptitudes and interests to aid in placement of patients in the convalescent program, and for recommendation of MOS for patients returning to duty and likely to be reclassified.

IV. Research, as directed by Headquarters AFPDC and the OIC of the Branch.

V. General Educational Development Tests, for patients and permanent party, used by USAFI and individual schools as standards for assigning academic credit.

VI. Such testing for patient or permanent party personnel as may be requested by the Classification Officer.

The Unit T Testing Section functioned as the only complete testing service until early March 1945. Then all separations activity moved to Unit S, and one enlisted man was assigned there to handle all separations testing. This work is described in the section on Separations.

At the same time, the Section at Unit T moved to two rooms in Cottage #8, one room for group testing and the other for individual testing as well as office space. Greater emphasis was thereafter placed upon research tests at Unit T (namely, the Convalescent Personnel Inventory, the Efficiency of Mental Application test, the Patient Attitude Scale, Part I and the Patient Attitude Scale, Part II) and such individual tests as are requested for Program Placement, by the Psychiatrists and Classification Officer for permanent party and patient evaluation, and by the patients for vocational and educational guidance. As the analysis of research tests is completed and bears fruit in group tests of value in the screening of operational fatigue and neurotic patients, and as instruments for use in program placement are perfected, it is expected that the Testing Section at Unit T will assume a more nearly routine processing function for screening and placement in the program. It continues its special diagnostic, guidance, and research testing functions, manned by two enlisted men under the supervision of the Officer in Charge of the Evaluation and Program Placement Section at Unit T.

The great need for clinical testing had been found to be at Unit B, and, after consultation with Lt. Col. E. H. Williams, Chief of Psychiatric Services, a Testing Section was organized. One officer and one EM on a part time basis began operations and soon, because of pressure of work, the EM was assigned to full duty with the Section. The services of Mrs. Dorothy H. Hertz, a psychologically trained civilian volunteer, have been utilized, and on 22 and 30 June, two additional enlisted men were assigned, one on a part time basis.

A great variety of cases ranging from simple mental defectives to the most complex psychotic conditions are handled, and many brain injuries are referred by the Surgical Services Division's Neuro-Surgical Branch at Unit B.

Cases are referred to the Testing Sections for consultation by Medical Officers attached to the Medical Services. A consultation form is transmitted to the Section, sometimes requesting specific techniques but more often stating the problem in general terms and requesting appropriate psychometrics. Each consultation form is considered by the OIC of the Section who schedules the patient, selects the tests to be administered and assigns an examiner to the case. After the tests have been administered, scored, and interpreted, a test report and summary of results is formulated by the Examiner and submitted for the approval of the Section OIC. Three times weekly, case conferences

are held at Unit B at which personnel of the Section present specially selected cases. After being approved, the report is sent to the medical officer concerned.

Since its inception, the Section at Unit B has examined an average of fifteen patients per week and has administered an average of forty tests per week. Cases referred have included mental defectives, psychoneurotics, psychotics, psychopaths, and cases involving neurological injury. Many recent referrals have come from the Neuro-Surgical Branch. Patients examined have included officers and enlisted men under care at the Biltmore and on the Beach, prisoners awaiting courts-martial, and civilian dependents of service personnel. Techniques administered have included the Rorschach Test, the Thematic Apperception Test, the Wechsler-Bellevue, the Army Individual Test, the Stanford-Binet, the Bellevue-Memory Test, the Shipley-Hartford Retreat Scale for Intellectual Impairment, the Hunt-Minnesota Clinical Test for Organic Brain Damage and the Continuous Addition Test. Educational and vocational tests are also utilized with convalescent patients and permanent party personnel fully desiring guidance.

Although requests for clinical psychometrics have been increasingly numerous, the program of the Section has been somewhat limited by lack of trained personnel and sufficient testing equipment. Clinically oriented personnel are now being trained in special techniques, as described later. Supplies of testing equipment originally contributed by Branch Personnel are now slowly being supplemented from military sources.

As a result of the clarification of the mission of the Psychological Branch in recent directives, the desire for expanded clinical testing and interviewing services on the part of Psychiatrists, and the assignment to this Branch of clinically trained personnel, two officers are now assigned to full time clinical work, assisted by two enlisted clinicians and one civilian.

Statistical summary of tests administered and numbers used follow.

STATISTICAL SUMMARY--TESTING AND COUNSELING FUNCTIONS

TABLE XVI

I. Personal Counseling
   A. Number Counseled
   B. Counseling Hours
   C. Tests Administered

II. Vocational and Educational Counseling
   A. Number Counseled
   B. Counseling Hours
   C. Tests Administered
      1. DE 504A Preference Record, Kuder
      2. DG 104A O'Rourke Vocabulary
      3. DG 203A Arithmetic Test
      4. DG 305A Figure Copying Test
      5. DG 306A Plotting Test
      6. DG 307A Spatial Test
      7. DG 308B Revised Minnesota Paper Form Board
      8. DG 401A Number Writing Test
      9. DG 603A Eye-Hand Coordination
      10. DG 604A Maze Test
      11. DG 605A Number Comparison
      12. DG 606A Name Comparison Test
      13. DG 607A Substitution Test
      14. DG 701A Peg Board Test
      15. DG 702A Finger Dexterity Test
      16. DG 703A Tweezer Dexterity Test
      17. DG 704A Motor Speed Test
      18. DG 705A Aiming Test
      19. Minnesota Test for Clerical Workers
      20. Progressive Achievement Test
      21. WM-AGO Battery General Aptitude
      22. Bernreuter Personality Inventory
      23. Otis Mental Ability Test
      24. Practical Judgement
      25. Mechanical Comprehension Test, Form BB
      26. Purdue Pegboard
      27. Minnesota Rate of Manipulation
      28. Industrial Training Classification Test
      29. California Mental Maturity Test
      30. Test of Clerical Ability
      31. American Home Scale
      32. Minnesota Vocabulary Test
      33. USES Mechanics Battery
      34. Strong Vocational Interest Blank
      35. Cornell Selectee
      36. Social Inventory
      37. Macquarrie Test of Mechanical Ability
      38. Bell Inventory
      39. AGO Mechanical Aptitude
      40. Otis Gamma
      41. Dept. Store Sales Person

TABLE XVI cont.

		28 Oct.-2 Dec.			3 Dec.- 9 Dec.			10 Dec.- 16 Dec.		
		Off.	EM	Tot.	Off.	EM	Tot.	Off.	EM	Tot.
I.										
	A.	5	7	12	5	24	29	6	23	29
	B.	7	10	17	3	15	18	4	13	17
	C.	0	0	0	0	0	0	0	0	0
II.										
	A.		72	72		34	34		48	48
	B.		651	651		210	210		270	270
	C.									
	1.	1	76	77		21	21		18	18
	7.		24	24		1	1		5	5
	19.					2	2			
	20.		2	2						
	22.		2	2						
	24.		1	1		1	1			
	26.		26	26		1	1		3	3
	27.		10	10		3	3			
	28.		19	19					1	1
	29.		10	10		2	2		4	4
	30.		7	7						
	31.		29	29						
	32.		1	1						
	33.								1	1

		17 Dec.- 23 Dec.			24 Dec.- 30 Dec.			31 Dec.- 6 Jan.		
		Off.	EM	Tot.	Off.	EM	Tot.	Off.	EM	Tot.
I.										
	A.	3	6	9	0	3	3	1	5	6
	B.	5	5	10	0	2	2	1	4	5
	C.	0	0	0	0	0	0	0	0	0
II.										
	A.		55	55		11	11		13	13
	B.		243	243		112	112		94	94
	C.									
	1.	3	13	16	1	5	6		3	3
	7.								2	2
	21.		3	3		2	2		2	2
	27.								1	1
	29.								2	2

TABLE XVI cont.

II.	7 Jan.- 13 Jan.			14 Jan.- 20 Jan.			21 Jan.- 27 Jan.		
	Off.	EM	Tot.	Off.	EM	Tot.	Off.	EM	Tot.
A.		24	24		26	26		19	19
B.		104	104		131	131		140	140
C.									
1.					5	5		4	4
7.		1	1						
21.					2	2		2	2
26.					2	2	1		1
27.					2	2	1		1
29.		1	1		2	2			

II.	28 Jan.- 3 Feb.			4 Feb.-10 Feb.			11 Feb.- 17 Feb.		
	Off.	EM	Tot.	Off.	EM	Tot.	Off.	EM	Tot.
A.	6	22	28	6	30	36	4	25	29
B.	10	180	190	13	219	232	6	331	337
C.									
1.		7	7		10	10		6	6
21.		1	1		9	9		9	9
24.								8	8
29.		1	1					1	1
30.	1		1						
34.	1		1						
35.	1		1						
36.	1		1						
37.	1		1						
38.	1		1						
39.	1		1						
40.								1	1

TABLE XVI cont.

II.		18 Feb.- 24 Feb.			25 Feb.- 3 Mar.			4 Mar.- 10 Mar.		
		Off.	EM	Tot.	Off.	EM	Tot.	Off.	EM	Tot.
	A.	4	23	27	4	19	23	3	46	49
	B.	9	315	324	9	180	189	3	420	423
	C.									
	1.	1	5	6		4	4		10	10
	2.					1	1		4	4
	3.								4	4
	4.								3	3
	5.								3	3
	6.								3	3
	7.		2	2		1	1		4	4
	8.								4	4
	9.								3	3
	11.								3	3
	13.								4	4
	18.								3	3
	19.					1	1		3	3
	20.					1	1		3	3
	21.		4	4		4	4			
	22.					1	1			
	23.					3	3			
	24.					1	1			
	29.		4	4						
	39.	1		1						

II.		11 Mar.-17 Mar.			18 Mar.-24 Mar.			25 Mar.-31 Mar.		
		Off.	EM	Tot.	Off.	EM	Tot.	Off.	EM	Tot.
	A.	5	21	26	1	57	58		23	23
	B.	5	210	215	2	215	217		210	210
	C.									
	1.		4	4		3	3		5	5
	2.		4	4		1	1		1	1
	3.		2	2		1	1		2	2
	6.		2	2		1	1		2	2
	7.		2	2		2	2		1	1
	8.		2	2						
	11.		2	2						
	13.		2	2						
	16.								1	1
	20.		4	4		1	1		1	1

TABLE XVI cont.

		1 Apr.-7 Apr.			8 Apr.-14 Apr.			15 Apr.-21 Apr.		
		Off.	EM	Tot.	Off.	EM	Tot.	Off.	EM	Tot.
I.										
	A.								1	1
	B.								1	1
II.										
	A.	6	29	35	3	29	32	4	27	31
	B.	11½	224	235½	6	305	311	9½	246	255½
	C.									
	1.		4	4	1	2	3		2	2
	2.		3	3	1	1	2	1	2	3
	3.		3	3	1	1	2	1	2	3
	4.		2	2	1	2	3	1		1
	5.		1	1						
	6.		3	3	1	2	3	1	2	3
	7.		2	2	1	1	2	1		1
	8.		3	3	1	1	2			
	9.				1		1			
	10.				1		1	1		1
	11.		3	3	1	1	2	1		1
	12.		3	3	1	1	2			
	13.		3	3	1	1	2			
	14.					1	1			
	15.					2	2			
	16.		2	2		2	2		2	2
	17.				1	1	2	1		1
	18.				1	1	2			
	19.				1		1		1	1
	20.		1	1	1	1	2			
	25.								3	3

TABLE XVI cont.

II.	22 Apr.-28 Apr.			29 Apr.-5 May			6 May-12 May		
	Off.	EM	Tot.	Off.	EM	Tot.	Off.	EM	Tot.
A.	2	5	7	3	1	4	6	3	9
B.	½	1½	2	11	2	13	32	21	53
C.									
1.				2		2			
2.				1		1	1		1
6.				1		1			
7.				1		1			
13.				1		1			
16.							1		1
20.				2		2			
39.		44	44						
41.				1		1			

II.	13 May-19 May			20 May-26 May			27 May-2 Jun		
	Off.	EM	Tot.	Off.	EM	Tot.	Off.	EM	Tot.
A.	4	5	9	1	4	5	3	7	10
B.	21	41	62	2	6	8	6	14	20
C.									
1.	1		1	2	1	3		1	1

TABLE XVI cont.

		3 June-9 June			10 June-16 June			17 June-23 June		
		Off.	EM	Tot.	Off.	EM	Tot.	Off.	EM	Tot.
I.										
	A.		1	1						
	B.		2	2						
	C.									
II.										
	A.	2	5	7	7	8	15	1	19	20
	B.	3	8	11	7	9½	16½	1	24	25
	C.									
	1.								2	2
	2.								1	1
	4.					1	1			
	7.					1	1		1	1
	9.					1	1			
	13.					1	1			
	16.								1	1
	41.								2	2

		24 June-30 June		
		Off.	EM	Tot.
II.				
	A.	2	4	6
	B.	2	6	8
	C.			

STATISTICAL SUMMARY--TESTING AND COUNSELING FUNCTIONS

TABLE XVII

28 Oct.-30 Jun.

		Off.	EM	Tot.
I.	Personal Counseling			
	A. Number Counseled	53	405	458
	B. Counseling Hours	20	52	72
	C. Tests Administered	0	0	0
II.	Vocational and Educational Counseling			
	A. Number Counseled	77	714	791
	B. Counseling Hours	169½	5143	5312½
	C. Tests Administered			
	1. DE 504A Preference Record, Kuder	12	211	223
	2. DG 104A O'Rourke Vocabulary	4	18	22
	3. DG 203A Arithmetic Test	2	15	17
	4. DG 305A Figure Copying Test	2	8	10
	5. DG 306A Plotting Test	0	4	4
	6. DG 307A Spatial Test	3	15	18
	7. DG 308B Revised Minnesota Paper Form Bd.	3	50	53
	8. DG 401A Number Writing Test	1	10	11
	9. DG 603A Eye-Hand Coordination	1	4	5
	10. DG 604A Maze Test	2	0	2
	11. DG 605A Number Comparison	2	9	11
	12. DG 606A Name Comparison Test	1	4	5
	13. DG 607A Substitution Test	2	11	13
	14. DG 701A Peg Board Test	0	1	1
	15. DG 702A Finger Dexterity Test	0	2	2
	16. DG 703A Tweezer Dexterity Test	1	8	9
	17. DG 704A Motor Speed Test	2	1	3
	18. DG 705A Aiming Test	1	4	5
	19. Minnesota Test for Clerical Workers	1	7	8
	20. Progressive Achievement Test	3	14	17
	21. WM-AGO Battery General Aptitude	0	38	38
	22. Bernreuter Personality Inventory	0	3	3
	23. Otis Mental Ability Test	0	3	3
	24. Practical Judgement	0	11	11
	25. Mechanical Comprehension Test, Form BB	0	3	3
	26. Purdue Pegboard	1	32	33
	27. Minnesota Rate Of Manipulation	1	16	17
	28. Industrial Training Classification Test	0	20	20
	29. California Mental Maturity Test	0	27	27
	30. Test of Clerical Ability	1	7	8
	31. American Home Scale	0	29	29
	32. Minnesota Vocabulary Test	0	1	1
	33. USES Mechanics Battery	0	1	1
	34. Strong Vocational Interest Blank	1	0	1
	35. Cornell Selectee	1	0	1
	36. Social Inventory	1	0	1
	37. Macquarrie Test of Mechanical Ability	1	0	1
	38. Bell Inventory	1	0	1
	39. AGO Mechanical Aptitude	2	44	46
	40. Otis Gamma	0	1	1
	41. Dept. Store Sales Person	1	2	3

TESTING--NOT ELSEWHERE REPORTED
TABLE XVIII

I. Civilians--dependents of soldiers

	Code	Name	No.
A.	DE 301C	Rorschach Technique, Free Response	1
B.	DE 302A	Thematic Apperception Test	1
C.	DG 902A	Wechsler Bellevue Test	1
D.		Stanford Binet Test (1936)	2

II. General Educational Development Test	Off.	EM	Tot.
A. College Level	10	4	14
B. High School Level	2	16	18

III. Officers Candidate Test		14	14

IV. Research Testing

A.	DE 207X1	Convalescent Personal Inventory	95	150	245
B.	DE 407A	Patient Attitude Scale	77	121	198
C.	DE 602A	Efficiency of Mental Application	21	122	143
D.		Convalescent Attitude Scale	31	110	141

VOCATIONAL GUIDANCE FUNCTIONS IN THE SEPARATION SERVICE

Original Program at the Biltmore Hospital

A CDD Section was organized in the AAF Regional Station Hospital #1 at Coral Gables, Florida in March 1944 under the direction of Capt. Marvin W. Webb with the assistance of two personnel consultant assistants, in order to handle the men being discharged for medical reasons. In view of the fact that the separation technique was a relatively new one, the program developed was of primarily local origin. Shortly after the organization of the CDD Section, it was re-named the Separation Service which handled both enlisted personnel and commissioned officers. The program was divided into several phases:

I - Lectures

"Human Engineering" - The scientific approach to proper selection of an organization's personnel, the rights and privileges of a veteran, and problems that veterans face.

II - Psychometrics

A short battery of tests given to every man going through the service to determine his interests and aptitudes.

III - Tours Through Local Industries

IV - Personal Discussions with Representatives of the Veterans' Administration and the United States Employment Service

As no plan had been developed to process CDD's within any given time after appearance before the CDD Board, this program was an extensive one which, in many individual cases, took place over a period of several weeks.

When the new program was established at the AAF Convalescent Hospital, Miami Beach, Florida, a large percentage of the patients who passed the CDD Board at the Biltmore Hospital were transferred to the new Separation Service on the Beach, with the result that the only personnel processed at the Biltmore were commissioned officers, bedridden patients, and psychiatric patients who had to be confined.

The Original Separation Program at Unit T

In October 1944, a Separation Service was established in the AAF Convalescent Hospital, Miami Beach, Florida, under the general direction of the Chief of the Convalescent Services Division. A locally available officer, Lt. Meredith W. Darlington (2235), was assigned to

administer the program. With the activation of the Program Placement and Psychological Branch with Major Edward I. Strongin as Chief, the Separation Service became the Vocational Counseling Section of that Branch. The personnel of the Separation Service included one officer, one enlisted man transferred from the Separation Service at the Regional Hospital, and two enlisted psychologists assigned to the Psychological Branch from the AAF Training Command. These men carried on a five-day program for personnel who had passed the CDD Board. Officer separations were handled entirely on an individual basis except as attendance at group activities was desired by the separatee. The program consisted of the following:

I - Lectures

"G.I.Bill of Rights and Public Law #16" (A discussion of legal benefits for veterans in general, and disabled veterans).

"You Are What You Are - Discover It" (A discussion of aptitudes).
"Because You Are a Veteran" (The rights and privileges of a veteran).
"Your Place in the Sun" (Job opportunities).
"Choosing a Job" (An approach to that problem).
"United States Employment Service and the Veteran"

II - Psychometrics

Other personnel of the Program Placement and Psychological Branch were called in to assist in administering interest and aptitude tests to those dischargees who did not have any definite vocational plans for the future.

III - Counseling

Personal interviews were available for those patients who presented psychiatric problems. Referrals to civilian mental hygiene clinics and family welfare agencies were given to the men informally. They were made aware of what these organizations might accomplish in bringing them back to complete health and well-adjusted daily existence.

IV - Reading Materials

Dischargees were encouraged to use the Vocational Kit which included information about all types of jobs. In connection with these readings, the counselors discussed the various jobs in which the dischargees showed interest.

V - Registration with the United States Employment Service

A representative was available at Unit T at appropriate times.

VI - Personal Conferences to Handle Insurance Problems

Conducted by Personal Affairs Officer.

VII - Interviews to File Pension Claims

Conducted by American Red Cross.

In addition to the personnel of the Vocational Counseling Section of the Psychological Branch, the assistance of the Personal Affairs Officer, a Red Cross Social Worker, a U.S.E.S. Representative, and a Veterans' Administration Representative was utilized. On 6 January 1945, Captain Donald E. Super replaced Major Strongin as Chief, Program Placement and Psychological Branch, and, partly because of his background in vocational guidance, assumed a more active part in the Separation Service on 4 March 1945. Captain Super was appointed Separations Officer as additional duty, with Lt. Darlington as Assistant, additional duty. Table ~~XXVIII~~ XIX shows the organization as set up at that time and effective until 8 May 1945.

In February 1945, the Army Separation Qualification Record, Form 100, was introduced as part of the discharge procedure. The decision was also made to develop a Vocational File which coordinated all personal information useful to a veteran. In addition to the general information, there was also included a summary of all tests given to the individual, their interpretation, and a discussion of vocational plans. The Vocational File included the following pages:

Title Page (Name and address of dischargee)
A Letter of Farewell Signed by the Officer in Charge of Vocational Counseling
Facts About the Selective Service Board
Facts About the United States Employment Service
Facts About the Apprenticeship Training Program
Facts About Other Organizations Pertinent to the Problem of the Individual Soldier
Facts About the Educational Provisions of the G.I. Bill of Rights
Facts About Priorities for Veterans
Army Separation Qualification Record, Form 100
Vocational Guidance Profile (Results of Tests)
Vocational Plans

The Vocational File and the Form 100 were not formally used until March 1945 after problems of approval and procurement were solved.

When the AAF Regional Station Hospital #1 and the AAF Convalescent Hospital were combined to form the AAF Regional and Convalescent Hospital on 1 January 1945, the decision was made to organize one Separation Service which would process all dischargees except bedridden and other special cases separated by other Psychological Branch personnel working at Unit B. By this time the Unit B program had decreased considerably in volume.

III - The Separation Service at Unit S

In April 1945, the entire Separation Service Program was transferred to the Surfside Unit. In addition, the program was reorganized to cover a 72-hour schedule as per War Department directives. Activities with the Veterans' Administration, the War Manpower Commission, the United States Employment Service, the Civil Service Commission, the Red Cross, and the Selective Service System were more closely coordinated under the Separations Officer. Representatives of the Veterans' Administration and the United States Employment Service were placed on full-time duty with the Separation Service.

The program of the Separation Service consisted of the following:

I - Lectures

"G.I. Bill of Rights"
"Rights & Privileges of the Veteran"
"Insurance Information"
"The United States Employment Service and The Veteran"
"Planning A Career"
"Job and Business Opportunities"
"The Apprenticeship Training Program for the Veteran"
"Getting Along with People"
"Problems in Becoming A Civilian"

These lectures were augmented by several films on the G.I. Bill of Rights and factory management procedures.

II - Psychometrics

A more carefully planned testing program was established with an enlisted psychologist in immediate charge. Tests were given to those dischargees who were uncertain about their future vocational plans. The tests utilized were as follows:

1. Interest Tests

Kuder Preference Record
Strong Vocational Interest Inventory

2. Intelligence Tests

Army General Classification Test
Revised Army Alpha Test, Form 9
2abc Battery
Army Individual Test
Wechsler-Bellevue Adult Intelligence Scale

3. Aptitude Tests

Army Mechanical Aptitude Battery

War Manpower Commission Battery, Including:
Finger Dexterity
Tweezer Dexterity
Manual Dexterity Pegboard
Revised Minnesota Paper Form Board
Minnesota Rate of Manipulation Test
MacQuarrie Test of Mechanical Ability
Army Clerical Aptitude Test
Minnesota Vocational Test for Clerical Workers
O'Rourke Vocabulary Test, Form X-4

4. Personality Test

Bernreuter Personality Inventory

5. Achievement Tests

Progressive Achievement Tests, Advanced Series
General Educational Development Tests, USAFI

III - Handling of Psychiatric Problems

In view of the fact that many of the dischargees wish to receive further assistance in the handling of their personal problems, it was decided to expand the entire plan for referral to civilian agencies. The agencies utilized were those recommended by the National Committee for Mental Hygiene and the Family Welfare Association of America. Extensive discussions were planned for each individual presenting a problem, and when the latter requested a letter of introduction, the same was prepared for him. The entire problem of referrals for personal problems was placed under the direction of the counselors who had specialized in this type of work. Arrangements were made with the medical officer in charge of dischargees to obtain brief statements on the nature of disability and any possible effect that it might have on the dischargee's ability to work. The vocational and personal counselor then has an opportunity to evaluate more carefully any psychological problem that may exist.

IV - Reading Materials

The use of the Vocational Kit was extended perceptibly. It became a regular procedure for both officer and enlisted separations, and the reaction to the information obtained has been more than favorable.

V - Registration with the USES

Dischargees are registered with the United States Employment Service and prepared to handle their employment problems when they reach home.

VI - Insurance

Individual conferences are planned with a representative of the Veterans' Administration to consider problems of insurance and conversion.

VII - Claims

Interviews are planned with the Red Cross in order to file pension claims.

The schedule utilized for the three-day Separation Program appears in Table XX[redacted].

Incorporation of the Separation Service in the Personal Affairs Department

On the basis of AFPDC Ltr. 20-26, the Separation Service became part of the Personal Affairs Branch on 8 May 1945. Lt. Darlington was relieved from duty with the Program Placement and Psychological Branch and appointed Assistant Personal Affairs Officer with additional duty as Separations Officer. Although the OIC of the Psychological Branch pointed out that the intent of the directive was being violated, the enlisted counselors were detached from the Psychological Branch to the Personal Affairs Branch. This arrangement was soon corrected, however, by a clarification of the directive from Headquarters, AAF Personnel Distribution Command, which directed that personnel assigned to the Program Placement and Psychological Branch were not to be detached but should operate as a part of that Branch. Pending the assignment to the Personal Affairs Branch of two 275's, it was agreed that psychological personnel would continue to operate under the direction of the Separations Officer. After the arrival of additional personnel, the counseling was to be done by the Psychological Branch on a referral basis, all detached enlisted men and all counseling materials being returned to the Psychological Branch for operations under the supervision of an officer of that Branch, as shown in Table [redacted]X, XXII

At the present time there are no accurate statistics to indicate the number of dischargees who were processed in the Separation Service at the Regional (Biltmore) Hospital. However, the number of dischargees processed at Units T and S are as follows:

The Total Number of Enlisted Men and Women
Processed at Units T and S as of 30 June 1945.....839

As of 30 June 1945, the number of commissioned officers who have gone through the Separation Service is..... 66
These statistics do not include those patients who were still bedridden and discharged to Veterans' Facilities or hospitals of their own choice.

Separatees at Unit B are processed by the Assistant Personal Affairs Officer at that Unit and by Psychological Branch personnel. Since mid-June the role of the latter has been confined to the testing and counseling of a few bed-ridden patients likely to be employable in due course and requesting guidance.

At the present time, a number of improvements are contemplated in the Separation Service Program. It is considered highly desirable to give the dischargee a Personal File which will include all information not found in the Vocational File. This file will include a brief discussion of the functions of the Veterans' Administration, the utilization of mental hygiene clinics and family welfare agencies, and individual recommendations.

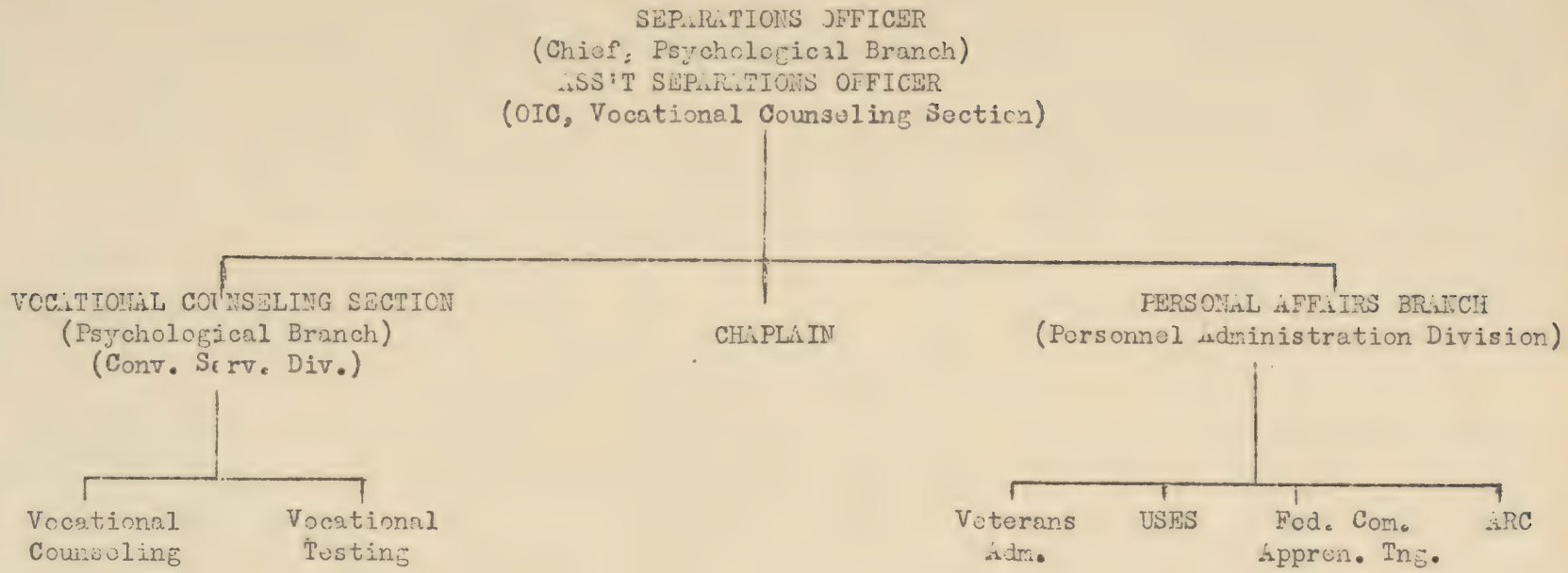
Furthermore, while it is purely voluntary for retired officer personnel to take advantage of the Separation Service, it has been found that many officers present problems which are at least equal to those of discharged enlisted personnel. Therefore, it has been suggested that the Separation Service Program be made mandatory for all officer personnel.

It has always been believed that a follow-up of separatees would be extremely valuable in giving further assistance to the more serious cases and provide data useful in improving the techniques utilized. A questionnaire has been tried but it has not proven to be completely successful. A revised questionnaire is being constructed which should be free from the defects of the first form. This questionnaire is also designed to give an indication of how rapidly dischargees readjust to civilian life.

TABLE XIX

ORGANIZATION CHART SEPARATION SERVICE

(4 March 1945 to 8 May 1945)



RESTRICTED

SEPARATION SERVICE PROGRAM
TABLE XX

72 Hour Schedule

Time	1st Day	Time	2nd Day	Time	3rd Day
0830 0845	***** ORIENTATION	0830 0930	***** GI BILL OF RIGHTS AND PUBLIC LAW #16	0830 0930	***** GETTING ALONG WITH PEOPLE
0845 0930	* BECAUSE YOU ARE A VETERAN	0930 0945	*** U.S.E.S. AND THE VETERAN	0930 1200	TERMINAL CONFERENCES Vocational Counselor goes over Vocational File with Dischargee and presents it to him.
0940 0950	** CHAPLAIN'S TALK	0945 1200	CONFERENCES Vocational Counselors Personal Affairs Officer Red Cross Veterans Representative U.S.E.S. Representative Individual Testing		If necessary, conferences with Personal Affairs Officer Veterans Representative Red Cross
0950 1000	DIRECTIONS FOR CONFERENCES				
1000 1200	INITIAL INTERVIEWS				
1300 1330	* INSURANCE INFORMATION	1300 1330	**** APPRENTICE TRAINING PROGRAM	1300 1400	***** PROBLEMS IN BECOMING A CIVILIAN
1330 1400	***** YOU ARE WHAT YOU ARE-- DISCOVER IT	1330 1430	***** JOB & BUSINESS OPPORTUNITIES Civil Service Agriculture Professional Industrial Starting Your Own Business	1400 1630	* FINAL DISCHARGE PROCEDURES Personnel Office Transportation Discharge
1400	GROUP TESTING or CONFERENCES	1430	CONFERENCES (same as 0945)		

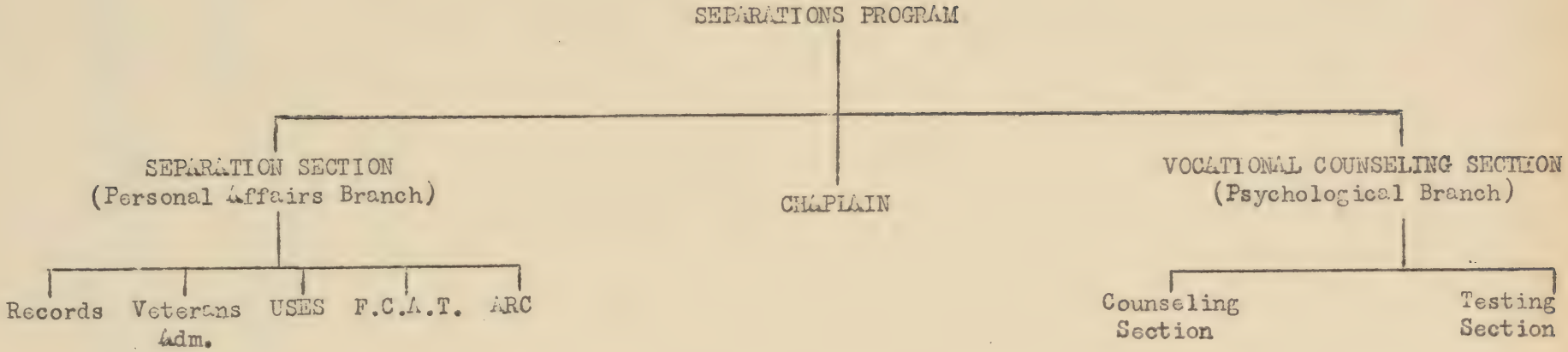
* Talk given by Veterans Administration Representative
** Talk given by Chaplain
*** Talk given by U.S.E.S. Representative
**** Talk given by Apprentice-Training Programs Representative
***** Talk given by personnel of the Psychological Branch
All other talks given by personnel of the Personal Affairs Branch

TABLE XXI
Statistical Summary
Separation Service

Month	Number of EM and EW Per Week	Total Number Per Month
1944		
OCT. 24-31	17	17
NOV. 1- 7	4	
8-14	11	
15-21	14	
22-30	26	55
DEC. 1- 7	29	
8-14	48	
15-21	36	
22-31	24	137
1945		
JAN. 1- 7	0	
8-14	17	
15-21	26	
22-31	39	82
FEB. 1- 7	28	
8-14	34	
15-21	5	
22-28	17	84
MAR. 1- 7	21	
8-14	50	
15-21	19	
22-31	36	126
APR. 1- 7	28	
8-14	28	
15-21	25	
22-30	41	122
MAY 1- 7	21	
8-14	23	
15-21	27	
22-31	40	111
JUNE 1- 7	22	
8-14	29	
15-22	27	
23-30	27	105

TABLE XXII

ORGANIZATION CHART
SEPARATION SERVICE
(30 June 1945)



SECTION LV

RESEARCH ACTIVITIES

Provision was made for the establishment of a Research Section upon inauguration of Branch activity on 9 October 1944, but due to lack of personnel research activities were not initiated until 19 November 1944. The experimental stage of development of the Convalescent Program at this hospital during the initial 7-month period of operation of the Research Section made it largely necessary to subordinate activities to the service functions of the Branch, both in allocation of personnel and admininstrative attention. Until 1 January 1945, research was a full-time assignment for only one man; at that time the Section consisted of two enlisted men, and on 25 June 1945 it was staffed by one full-time officer and three full-time enlisted men. With the increasing stabilization of the program, the research functions have received more attention.

The function of the Research Section is that of "conducting research and making reports on such research for the purpose of improving psychological procedures and techniques, developing new methods, and obtaining data on the psychological characteristics of patients as may be required for the efficient operation of the Branch or as directed by higher authority." (AFPDC Regulation No. 20-19, dated 28 October 1944, Headquarters, AAFPDC, Atlantic City, N.J.) In line with this directive and in the light of the problems confronting a newly-launched psychological program, highest priority has been necessarily alloted to research projects which would assist the other sections of the Branch and other Branches of the hospital by providing information of direct utility to them in the performance of their mission. Thus, techniques for description and analysis of patient behavior, serving as bases for recommendations regarding program placement, counseling, disposition, and the like, have been or are in process of being developed in the form of interest inventories, attitude scales, measures of adjustment, measures of mental dysfunction, adjustment interviews, and biographical records. The revised AFPDC Regulation 20-19, dated 9 May 1945, which does not apply to this Station directs the Psychological Branches to conduct "such research and follow-up studies as may be of value in defining the interests, attitudes, problems, and needs of patients, and in developing and evaluating techniques required for the other functions of the Branch."

The selection of research projects has been guided by the local needs of the Convalescent Services Program, the Plan for Research outlined by Headquarters, AAFPDC, in the December 1944 Monthly Report of Psychological Research, and both the 28 October 1944 and 9 May 1945 AFPDC Regulation 20-19.

The major portion of the research projects have concerned themselves with "constructing and validating tests required for the program" and with "conducting certain evaluative research studies on the effective-

ness of the contributions of psychological and other procedures to the achievement of the convalescent program", two of the three areas of research outlined in the December 1944 bulletin referred to above. Local conditions militated against research in the third field recommended, "developing criteria against which tests and procedures can be evaluated". However, in a sense, the Convalescent Personal Inventory, project M-1, may later be used as a criterion for the validation of other measures.

Description of the various projects undertaken and the progress made to date thereon follows in the next section of this report.

Projects

M-1. Construction of Convalescent Personal Inventory, DE207X-1.

a. Purpose: Development of an inventory useful in diagnosing operational fatigue.

b. Method: An exhaustive list of symptoms of the operational fatigue syndrome based on available authoritative literature and the experience of Branch personnel was compiled. At least one item for each of these symptoms was then constructed in language readily understandable and most meaningful to the population on which this instrument was to be used. The completed preliminary form of the inventory comprised 90 items. The examinees were instructed to indicate a "Yes" or "No" response by filling in the appropriate spaces on an IBM answer sheet.

c. Results: This inventory was administered in small groups to 206 operational fatigue patients at Unit T and to a control group of 264 non-operational fatigue returnees at the Psychological Branch, Surgeon's Division, AAF Redistribution Station #2, Miami Beach, Florida. Data obtained were treated as indicated below and the following results were obtained:

On the basis of an item analysis of half the total number of cases (Group A), a 50 item test was constructed which was believed to possess good discriminatory power. The remaining half of the papers (Group B) were scored with the scoring key based on the first half. Weighting each item 2 points, the scores were distributed on a 100 point scale, on which the score indicates the percentage of items answered in a manner characteristic of an operational fatigue population. Group B operational fatigues obtained a mean score of 49.5, and the non-operational fatigues a mean score of 26.5. The highly significant difference between the two means was shown by the obtained critical ratio of 9.2. The meaning of this difference was more fully revealed in the biserial correlation coefficient (validity coefficient) of .65 between psychiatrists' diagnoses and test scores. Corrected for attenuation, the odd-

even reliability coefficient for these data was .92. Thus, it was concluded that the 50 item Convalescent Personal Inventory was a very satisfactory diagnostic test for operational fatigue.

d. Applications and Future Research: The Convalescent Personal Inventory has a four-fold usefulness:

(1) As a preliminary screening test.

(2) As a psychiatric aid in doubtful cases.

(3) If administered to patients at both admission and discharge, it may be used as an instrument to evaluate amount of improvement in operational fatigues during their stay at a Convalescent Hospital. Such a project is now in the planning stage.

(4) As a preliminary step in the construction of an instrument capable of adequately discriminating between mild and severe operational fatigues. Such an instrument has already been developed in the form of a multiple choice form of the Convalescent Personal Inventory. Data will shortly be gathered with this instrument, to ascertain whether symptoms differentiating operational fatigue patients from normals can, when opportunity is provided the examinee to report the degree or frequency of his symptoms, serve as a measure of the severity of operational fatigue.

M-2. Development of a Patient Attitude Scale: Part I, DE407A.

a. Purpose: To construct a scale to measure the attitudes of patients towards the purposes and functioning of a Convalescent Hospital.

b. Method: An initial group of items indicating attitudes toward a Convalescent Hospital was evaluated by 20 experienced judges who indicated whether, in their opinion, the attitude expressed by each of these items was desirable or undesirable from the Army point of view. Statistical treatment of the judges' ratings, based on an 80% agreement criterion, yielded a scale of 10 items possessing least ambiguity and most plausibility in the attitude being measured. This tentative scale was administered to 114 patients at the time of initial interview for the dual purpose of evaluating the scale and determining the attitude of patients toward the hospital. The first five items expressed attitudes of varying degrees of favorableness to the hospital and the last five were statements of unfavorable attitudes.

c. Results and conclusions:

(1) The following distribution of responses for each item was obtained, showing a high degree of consistency in responses to the various items in the scale:

TABLE XXIII

Distribution of Responses for Each Item

Item No.	%Strongly Agree	% Agree	% Disagree	%Strongly Disagree	%No Response
1	43.8	55.3	0.0	0.0	0.9
2	34.2	59.7	6.1	0.0	0.0
3	36.0	64.0	0.0	0.0	0.0
4	26.9	64.9	5.3	0.0	0.9
5	33.3	65.8	0.9	0.0	0.0
6	2.6	3.5	73.7	20.2	0.0
7	1.7	5.3	55.3	37.7	0.0
8	1.7	4.4	47.4	46.5	0.0
9	0.0	0.9	35.1	62.3	1.7
10	0.0	2.6	43.0	54.4	0.0

(2) Weights of -2, -1, 1, and 2 were assigned respectively to strongly disagree, disagree, agree, strongly agree responses to items expressing favorable attitudes. Items expressing unfavorable attitudes were scored inversely. Thus, the total possible range was from -20 to +20. Obtained distribution of scores, however, ranged from +3 to +20 with a mean of +13.2 which may be interpreted as indicating that all of the patients tested demonstrated attitudes varying from mildly favorable to very favorable.

d. Further research:

(1) In order to measure whether changes occur in patient attitudes toward the Convalescent Hospital during their stay at Unit T, a study is now in progress in which patients who were tested at the time of their initial interviews are being retested with the scale at the time of their terminal interviews.

(2) Since it was planned originally to administer the scale terminally to the same group tested initially, patients were required to sign their papers for purposes of reference. However, in order to be sure that patients who sign their names are answering the scale frankly, a study is now under way in which the scores of a group being tested anonymously are to be compared with scores of a group of patients who are required to sign their papers.

(3) In order to ascertain whether patient attitudes toward the hospital fluctuate over an extended period of time, it is planned to administer the scale to small samples periodically.

M-2. Development of a Patient Attitude Scale; Part II, DE407A.

a. Purpose: To construct an attitude scale consisting of ten parts, or sub-tests, which will measure the attitudes of convalescent patients in the following areas:

(1) Status of Returnee
(2) The Home Front
(3) Soldiers Continentally Stationed
(4) The Army System
(5) The War
(6) Second Tour of Overseas Duty
(7) Return to Civilian Status
(8) The Japanese
(9) Return to Duty in Same MOS
(10) Flying Status

b. Method: Items were originally compiled from comments of patients, literature, and on an a priori basis. The items were then rated by 20 qualified judges in terms of the desirability or undesirability, from the Army's point of view, of the attitudes represented by these items, on a five-point scale of very desirable, desirable, uncertain, undesirable, very undesirable. A criterion of 80% agreement among the judges was used in selecting items for the final preliminary form. The best items in this selection were then included in the initial scale, consisting of 10 or 12 items in each of the ten areas, a total of 112 items for the complete scale. The first half of the items in each sub-test expresses favorable and the second half unfavorable attitudes. Items are in the form of simple statements to which the patient is asked to express one of the following judgments: Strongly Disagree, Disagree, Agree, Strongly Agree. The responses are given scoring weights of 1, 2, 4, 5, respectively for responses to favorable items, and inversely for responses to items expressing unfavorable attitudes. In the selection of items for the final form, such additional factors as internal consistency and plausibility will be considered. Reliabilities and intercorrelations of sub-tests will be computed. An attitudes profile will be obtained from the scores on the sub-tests. Scores on each sub-test will be translated into percentile ratings. A total score may also be obtained, but its meaningfulness is open to question unless it can be demonstrated that there is a general attitude factor being measured by all the sub-tests. The profile technique will permit the development of additional attitude scales, so that, in effect, an attitudes battery will be developed.

c. Progress: Administration of the scale was begun on 30 May 1945. One hundred and nine cases having been obtained, the results are now being analyzed.

M-3. Relationship Between Efficiency of Mental Application Test Scores and Operational Fatigue.

a. Purpose:

(1) To determine whether operational fatigue patients demonstrate an impairment of efficiency of mental application as measured by the EMA Test.

(2) To determine whether an improvement in EMA Test scores occurs during the patients' stay at the Convalescent Hospital.

b. Method: It is proposed to obtain a sample of sufficient operational fatigue cases at the time of their initial interview to obtain about 50 terminal cases. The mean and sigma of the initial test scores will be computed and compared with the norms obtained by the test author. The critical ratio of the mean initial and mean terminal scores will be computed to determine whether a statistically significant improvement has occured. A control group of an equivalent number of non-operational fatigues will be tested initially and twelve days later (the average time interval between initial and terminal testing of operational fatigues) to determine the effect of practice, and whether non-operational fatigues as a group have a significantly different mean score on the EMA test than do the operational fatigues.

c. Progress: Eighty-two operational fatigue patients have been tested at the time of their initial interview and 26 have been retested at the time of their terminal interviews. Twelve non-operational fatigue cases have been tested initially and five terminally.

M-4. Questionaire Concerning Attitude Toward Convalescent Orientation, Phase III.

a. Purpose:

(1) To ascertain the degree of patients' interest in the Continuous Orientation classes.

(2) To ascertain the advisability of offering additional classes in the subject.

(3) To obtain criticisms and suggestions for improving the course, from the patients' point of view.

(4) To discover areas of particular interest to the patients, as demonstrated by their questions, to be used as bases for future discoveries.

b. Method: The following anonymous questionaire is administered periodically to patients enrolled in the continuous orientation course:

* * * * * *

CONTINUOUS ORIENTATION SURVEY

Have you learned anything in this course? _____
This course has been (very interesting) (interesting) (uninteresting) (dull).
Would you be interested in attending additional classes on a voluntary basis? _____
(List any questions you would like answered and any comments or criticisms of the course on the back of this slip).

* * * * *

c. Results and conclusions: To date, the following results have been obtained:

TABLE XXIV

Interest in Convalescent Orientation

1.	Learned Something	127
	Learned Nothing	11
	No Response	3
2.	Very Interesting	42
	Interesting	92
	Uninteresting	2
	Dull	4
	No Response	1
3.	Would Elect More	80
	Would not Elect More	48
	No Response	13

The results indicate that the general reaction to the Continuous Orientation course is favorable.

M-5. Development of a Separatee Vocational Interest Inventory, and M-6. Follow-up of Men Processed by the Separation Service.

a. With the transfer of the Separation Service to the Personal Affairs Branch, work on both of these projects was discontinued by the Program Placement and Psychological Branch. One or both may later be resumed if work on a referral basis justifies it.

M-7. Development of Techniques for Measuring Patients' Attitudes Towards Various Phases of the Convalescent Hospital.

a. Purpose: To develop a measuring device for sampling patient

opinion on various specific phases of the convalescent program and to furnish an information service to Branch and Section chiefs.

b. Method: Construct items after consultation with appropriate Branch and Section chiefs to determine what phases of their program might be evaluated. The completed questionaire is to be administered to patients as a regular feature in terminal evaluation. The results are to be tabulated and presented in report form periodically to interested authorities.

c. Progress: To date, items have been constructed in the following areas and the questionaire is being prepared for administration:

(1) Educational Branch Activities
(2) Physical Reconditioning Program
(3) Recreational and Entertainment Facilities
(4) Hospital Facilities
(5) Administration and Processing
(6) Hospital Newspaper
(7) General Comments by Patients

M-8. Development of an Outline for Diagnostic Interviews and a Personal Inventory as Indices of Predisposition to Neurosis.

a. Purpose: Construction of a standardized case history and biographical data blank to fulfill the following objectives:

(1) As an immediate aid to the psychiatrist in prognosis and disposition and to the psychologist as a basis for educational and vocational counseling.

(2) As a research instrument for determining those personality characteristics of operational fatigue patients that distinguish them from non-operational fatigue patients.

(3) As a possible basis for the construction of a personality scale that will measure predisposition to psychoneurosis.

b. Rationale: The basic assumption of this study is that the factors of combat stress, exhaustion, and the like are significant in the development of operational fatigue only as they relate to personality tendencies. It is felt that combat stress accentuates trends towards neuroticism already present rather than inaugurating new modes of adaptation. It is believed that anxiety attached to a substantial number of situations through past experiences will handicap the individual in dealing with new threats to security such as are found in combat.

(1) The physical, sociological, and physiological aspects such as exhaustion, traumatic experiences, food, health, etc., should be measured in objective and quantitative terms--so many crashes and injuries, so many missions in a given period of time, and the like--and not in terms of the individual's reaction to those events. The latter is a psychological property and presumably a function of the individual's personality and development.

(2) The concept of predisposition is broadly interpreted to include any conception that the individual might have of himself and his abilities and of the demands various situations make on him that would tend to make him feel he is incapable of complying with the requirements of the situation. This would also include any reaction or behavior on the individual's part that could be interpreted in this way. In other words, it is assumed that the individual is maladjusted and therefore predisposed when his conceptions of his own abilities and prowess do not coincide within reasonable limits with what he conceives to be the demands and requirements made upon him by the situation. This discrepancy between the individual's conception is felt to be the essence of many so-called conflict situations.

(a) On the basis of this assumption, the degree of predisposition would be measured by the extent of the discrepancy between the individual's conception of himself and his conception of the demands of the situation. The measurement of the degree of maladjustment would involve two factors.

1 Extensiveness: This concept involves the number of different fields or situations in which such a disparity is found. An individual who felt inadequate in familial, social, sexual, and occupational situations would be considered more maladjusted than an individual whose feelings of inadequacy were limited to sexual relations.

2 Intensiveness: This is a concept of degree of more or less as related to feelings of inadequacy in any one situation. It is not assumed that it is independent of the "extensiveness" factor. But it is assumed that of two individuals having inadequacy feelings in the same situations, the one whose feelings are more intense would be more maladjusted.

(b) It is believed that the individual's conception of himself and of various generic situations arises and is largely brought into awareness through life-long experiences that involve his relations with others. Such experiences deal mainly with security, affection and prestige. Many of these are unique with the individual, but it is felt that there is a sufficient number common to all persons so that individuals can be validly compared as to their reactions to those experiences and thus as to their conception of their adequacy in meeting the situation. It is assumed that by judiciously selecting certain situations experienced by most individuals and involving the security, affectional relations, and prestige of the individual and then by adequately determining his reaction to these situations, it is possible to measure the extensiveness and intensiveness of his feelings of inadequacy and, therefore, of predisposition to maladjustment.

c. Method:

(1) A "Guide for Case History Taking" has been constructed with two goals: One, to cover various aspects of the psychological and sociological development of the individual and to include material on the combat conditions he experienced; Two, to make the interview sufficiently standardizédso that comparable data will be obtained on all individuals and yet allow sufficient latitude for the interviewer to make valid judgements regarding the individual's modes of reaction and feeling.

(a) The outline makes ample allowance for factual data of a sociological sort: parentage, home conditions, education, etc. It also provides for factual information about combat stresses: time overseas, missions, duties, traumatic experiences, etc. The main emphasis, however, is placed on developmental events felt to be conducive to feelings of insecurity: parental and social rejection, invidious comparisons, and personal failures.

(b) The projected interview form will demand that the interviewer check the relevant answer to each item demanding factual data. This will insure complete coverage and comparability of data. Room will be provided for the interviewer to enter his impression of how the individual reacted to the situation or experience.

1 To insure greater uniformity in the recording of the nature and intensity of a reaction or feeling, an interviewer's handbook is planned that will list various types of behavior and the clinical significance they have in the situations under exploration. This will be supplemented by instruction and discussion on the part of interviewing personnel.

(2) On the basis of the data collected on the interview forms, a brief case history and personality sketch will be written for each operational fatigue patient so that the psychiatrist will have a more adequate picture of each case.

(3) Once the interview form has been adequately standardized on operational fatigue cases, it is planned to gather histories on a comparable group of non-operational fatigue returnees. This will permit several important comparisons, both with regard to factual experiences and background and to psychological reactions.

(a) By statistical comparison of sociological and combat experience items, the importance or non-importance of these variables as related to operational fatigue can be determined. This will provide a more objective basis for the evaluation of these factors in theories of operational fatigue.

(b) The assumption underlying the psychological concepts of this project will be checked by comparing the reactions and feelings of the two groups. It is planned to score the psychological reactions on the basis of an a priori criterion of what constitutes a feeling of inadequacy in a clinical sense and also on the basis of the intenseness of the reaction. The reliability of such scoring can be readily determined. The scores will provide a measure of predisposition.

(4) If the interview form, as now planned, proves to be useful in differentiating groups and in determining predisposition and prognosis, it will be used as a routine processing instrument. Under these conditions it will be revised so that the factual data, and as much as possible of the psychological data, will be obtained through a self-administered biographical data form.

(5) By the selection of the most discriminating items, it should be possible to construct a relatively short scale of predisposition to maladjustment to use in processing. This

would provide a ready means of grouping operational fatigue patients for treatment and disposition and of selecting other types of patients that might need psychiatric attention.

d. Progress: The Guide for Case History Taking has been in use since 21 May 1945 with operational fatigue patients. Data are now on hand for the development of the more objective interview form.

M-9. Construction of an Activity Preference List.

a. Purpose: To construct a check list and rating scale for the evaluation of patients' experience and interest in educational, vocational, and avocational activities on entering and on leaving the hospital.

b. Method: To develop a list of activities now offered or likely to be offered at this Hospital, providing a means for the patient to indicate:

(1) Extent of experience in each activity prior to hospitalization.
(2) Degree of interest in each activity at time of admission.
(3) Three activities preferred at time of admission.
(4) Interest in activities taken at time of discharge.
(5) Three activities preferred at time of discharge.

It is proposed to administer this list experimentally at different times, e.g., before the Initial Orientation Tour, after the Tour, and on leaving the hospital, to ascertain the effects of contact with the program. The preference list will be used routinely in Initial Evaluation and Program Placement.

c. Progress: The list is now ready for typing in rough draft prior to final review and mimeographing for use.

M-10. Compilation of Statistics Concerning Patients in the Convalescent Services Division.

a. Purpose: Compilation of statistics on pertinent factors in the personal and military backgrounds of all patients processed through the Convalescent Services Division to serve the following purposes:

(1) As a means of accumulating data of possible significance in the diagnosis and treatment of operational fatigue for research purposes in the Program Placement and Psychological Branch and possible use in the Psychiatric Services Division.

(2) As an aid to officers in charge of the various Branches of the convalescent activities program in the formulation, improvement, and modification of policies and procedures.

(3) As information for the Chief of the Convalescent Services Division.

b. Method: An extensive list of factors of possible significance which are capable of statistical treatment was drawn up and incorporated into an "Interview Face Sheet" (see Form PSY-IRF-6). This form is utilized in all initial interviews. The information thus obtained will be accumulated continuously and will be reported in the form of statistical tables and graphs to the Chief, Convalescent Services Division, at monthly or semi-monthly intervals.

c. Progress: The Interview Face Sheet was put into general use at Unit T on 30 May 1945. In the period 30 May to 15 June inclusive, 106 patients were processed and the information obtained has been broken down as follows:

(1) Hospitalization Records:

(a) Diagnosis (percentage):

Operational Fatigue	- 47.1
Orthopedic	- 18.9
Surgical	- 19.8
Medical	- 14.2

(b) Patients having previous hospitalization records (percentage):

All patients	- 24.5

(c) Sources from which patients were admitted (percentage):

Pancoast Unit	- 62.3
Biltmore Unit	- 36.8
Nautilus Unit	- 0.9
Other	- 0.0

(d) Median time hospitalized in Miami Beach area prior to admittance to Unit T:

Operational fatigues	- 1.9 weeks
Other patients	- 3.8 "
All patients	- 2.3 "

(2) Army History:

(a) Percentage of all patients by rank:

Officers	- 13.1
Enlisted Men	- 86.9

(b) Percentage of Operational fatigue patients by rank:

Officers	- 14.0
Enlisted Men	- 86.0

(c) Percentage of Officers and EM diagnosed as operational fatigue:

Officers	- 50.0
Enlisted Men	- 46.7

(d) Method of entry into the service (percentage):

Enlistment	- 37.7
Induction	- 56.3
Reserve	- 6.0

(e) Median length of service:

Operational fatigues	- 31.2 months
Other patients	- 34.2 "
All patients	- 32.9 "

(f) Percentage of patients with overseas service:

Operational fatigues	-100.0
Other patients	- 82.1
All patients	- 90.6

(g) Median length of service overseas:

Operational fatigues	- 16.5 months
Other returnee patients	24.0 "
All returnee patients	- 21.0 "

(h) Percentage of returnee patients by theatre of operations in which they last served:

European	- 58.3
Pacific	- 39.6
Caribbean	- 2.1

(i) Percentage of returnees diagnosed as operational fatigues, by theatre of operations:

European	- 58.0
Pacific	- 42.0
Caribbean	- 0.0

(j) Percentage of patients by branch of service:

Air Forces	- 88.7
Ground Forces	- 11.3

(k) Percentage of patients previously on flying duty:

Operational fatigues	- 68.0
Other patients	- 25.0
All patients	- 42.5

(l) Median time in performance of primary duty:

All patients	- 22.1 months

(m) Percentage of patients who attended a service school:

All patients	- 58.5

(3) Personal History:

(a) Median age:

Operational fatigues	- 25.5
Other patients	- 28.0
All patients	- 27.0

(b) Median educational level:

Operational fatigues	- 11.9 years
Other patients	- 11.6 "
All patients	- 11.8 "

(c) Reason for leaving school (percentage):

Graduation	- 44.3
Economic	- 30.2
Other	- 25.5

(d) Main civilian occupations (percentage):

Professional	- 6.6

Business and managerial	- 12.3
Clerical	- 11.3
Skilled Trades	- 23.6
Semi-skilled trades	- 23.6
Farm	- 6.6
Unskilled	- 7.5
Student	- 8.5

(e) Median time of employment in main civilian occupation:

All patients	- 3.4 years

(f) Marital status (percentage):

Single	- 30.2
Married	- 67.0
Widowed	- 0.0
Divorced	- 1.9
Separated	- 0.9

(g) Percentage of patients who have children:

All patients	- 26.4

(h) Percentage of patients who have other dependants:

All patients	- 17.0

(i) Percentage of patients by size of home community:

Farm	- 12.3
Village	- 8.5
Town	- 20.8
City	- 59.4

(j) Percentage of patients by regional distribution:

New England	- 1.9
Middle Atlantic	- 10.4
Southeastern	- 33.6
North Central	- 28.3
Southwestern	- 10.4
Prairie	- 8.5
Mountain	- 0.0
Pacific Coast	- 1.9

Note: For purposes of this report, states have been divided into geographical areas as follows:

New England: Me., N.H., Vt., R.I., Mass., Conn.
Middle Atlantic: N.Y., N.J., Penna., Md., Del.
Southeastern: Va., W.Va., Ky., Tenn., N.C., S.C., Ga., Ala., Miss., Fla.
North Central: O., Ind., Ill., Wis.
Southwestern: Ark., La., Tex., Okla., N.M., Ariz.
Prairie: Minn., Iowa, Mo., Kan., Neb., S.D., N.D.
Mountain: Colo., Wy., Mont., Utah, Idaho, Nev.
Pacific Coast: Cal., Ore., Wash.

(4) Post-war plans:

(a) Percentage of patients planning to return to school:

Plan to return	- 29.2
Undecided	- 17.0
Will not return	- 53.8

(b) Percentage of patients planning to return to school who intend to utilize the educational provisions of the G.I. Bill of Rights:

For full support	- 46.9
Partial support	- 22.4
Undecided	- 28.7
No support	- 2.0

(c) Post-war occupational plans (percentage):

Return to same occupation	-43.7
Undecided	- 15.9
Enter a different occupation	- 40.4

(d) Post-war plans regarding home community (percentage):

Return to home community	- 81.1
Undecided	- 11.3
Move to different community	- 7.6

SECTION V

TRAINING ACTIVITIES

Diagnostic Testing Training Program:

Since the beginning of Branch operations at Unit B there has been an increase in referrals for clinical testing for the Psychiatric and Surgical Services Divisions. A point was reached late in May when the testing load was greater than could be handled by Branch personnel. Consequently, men were transferred from Unit T to B, and it was felt that a continuous training program should be instituted for the improvement of skills and standardization of procedures.

The clinical training takes place for the most part in case conferences held three times each week by the staff of the Testing Section. Presided over by the Officer-in-Charge, these meetings provide for continuous training of the entire staff and provide opportunity for consultation and the pooling of the clinical experience of the group. When new trainees attend, the meetings take the form of training sessions during which informal lectures and cases selected for their illustrative value are presented. No set training schedule is followed, as the training period content is made to conform to the needs of the individual trainees.

Early in the training period, the trainee is introduced to the Medical Officers from whom his referrals will come. The close personal relationship between the Medical Officers and the personnel of the section has proved an important factor in facilitating the work of both groups.

During the first case conference the trainee is acquainted with the types of cases which are referred to the Section, the bases of referrals, and the techniques of reporting findings. The first reading assignment is a review of Wechsler's The Measurement of Adult Intelligence and the trainee is expected to brush up quickly in the administration of the Wechsler-Bellevue Scale, an instrument used frequently by the Section. As soon as basic proficiency has been attained, the trainee administers the test several times under spuervision.

The second case conference is devoted to a discussion of clinical patterns on the Wechsler, case illustrations of these patterns, and an introduction to the Rorschach Technique. Extensive reading in the Rorschach test in Klopfer and Kelly and in Bochner and Halpern is assigned. Under individual guidance, proficiency in the administration of the technique is developed. Techniques of interpretation are taught individually and individual instruction is supplemented by discussions and cases in conferences. The same prodedure is followed in teaching the other techniques employed by the section. Practical application of reading is emphasized throughout.

At the same time that training is given in specific techniques, attention is paid to further orientation in Abnormal Psychology, with

special emphasis on the dynamics of those syndromes most commonly encountered at Unit B. Reading and written reports of research on specific syndromes is assigned. Talks and discussions covering the subject supplement the trainee's individual work.

In the later phases of training, synthesis of data and techniques of the psychological report are taught and practiced. When proficiency has been attained in this area, formal training is discontinued and the trainee assumes a full work schedule. Training incidental to the case conference continues indefinitely.

Convalescent Orientation Training Program:

An in-service training course in the Convalescent-Orientation Program of the Branch was instituted on 26 May 1945.

This course was designed to improve the psychological background of personnel of the Branch and to train additional potential discussion leaders.

Eight enlisted men were selected to attend the training sessions. They were chosen on the basis of a combination of their personality attributes that would make them suitable discussion leaders and at least a good elementary background in psychology.

The training course consisted of ten lecture-discussions designed to impart to the staff the basic psychological data needed to conduct the convalescent-orientation talks, to train personnel in proper techniques of leading group discussions, to impart elementary principles ofgrou therapy, and to provide information and source materials for the less psychological subject matter handled in the convalescent-orientation talks (such items as the GI Bill of Rights, veterans organizations, post-war problems, facts relating to the war effort by the home front, etc.)

A copy of the outline of the in-service training course is attached. The course is conducted to parallel the content of the ten lecture convalescent-orientation course.

* * * *

IN-SERVICE TRAINING COURSE IN CONVALESCENT ORIENTATION

I Purpose of this training course.
Philosophy and general techniques of our Continuous Orientation Course.
Content of Lecture #1, "Understanding Human Nature".

II Content of Lecture #2, "Understanding Our Emotions".

III Content of Lecture #3, "Adjusting to Difficulties", an explanation of the dynamics of operational fatigue with reference to pertinent articles in the literature on the subject.

IV Content of Lecture #4, "Forming Healthy Attitudes".

V Content of Lecture #5, "The Adjustment of the Returnee". Discussion of attitudes evidenced by returnees and methods of handling dissatisfactions of returnees.

VI Lecture on group discussion techniques.

VII Explanation of purposes and content of Lectures 6, 7, 8, "The War and the Nation", "The Serviceman and the Nation", and "The Serviceman, the War and the Future".

VIII Lecture on discussion materials, sources, and the content of the GI Bill of Rights and other relevant government legislation.

IX Content of Lecture #9, "Your Abilities and Your Future". Explanation of basic principles of vocational guidance and job placement and selection.

* * * *

X General discussion reviewing content of training course and answering questions raised by members of the class.

Evaluation Interview Training Program:

The training of interviewers in case history taking for program placement counseling has been carried on informally at Unit T and B, as new men were assigned to that type of work and as new procedures were initiated. Evaluation interviews for use in psychiatric work have been developed at both Unit T and B, as described elsewhere, and training in procedures has been carried on at both Units by appropriate officers. Now that the Branch is fully manned, it is expected that a formal program of training in clinical history taking and in personal, education, and vocational counseling will be initiated.

SECTION VI

EVALUATION AND FORECAST

Organization

According to AFPDC Regulation 20-19, dated 28 October 1944, the Program Placement and Psychological Branch was one of four branches of the Convalescent Services Division, and its principal mission was in that Division. Its activities in convalescent orientation and in evaluation and program placement were to make it possible for the patient to derive the maximum possible benefit from convalescent therapy. Such testing, counseling, and research as were done were to be primarily for the same purpose, although testing to assist psychiatrists in diagnosis, counseling of patients concerning long-term educational plans and personal problems, and research not strictly related to the improvement of convalescent training were also approved.

However, the Chiefs of the Psychiatric Services and Surgical Services Divisions had been used to utilizing psychological services, and therefore requested that psychological personnel be assigned to Unit B who might provide clinical diagnostic testing and case history taking services for their divisions. With the approval of the Director of Hospital and Professional Services and of the Chief of the Convalescent Services Division this was done. Similarly, since the Psychological Branch was responsible, according to the same directive, for vocational counseling of separatees, this Branch was at first in charge of separations and, when AFPDC Ltr. 20-26, dated 9 April 1945, was received, was made responsible for separation counseling. Despite AAF Ltr. 39-59, dated 19 May 1945, making separation classification and counseling the function of the Personal Affairs Branch, the Psychological Branch continues, at the request of the Personnel Division, to provide vocational counseling services on a referral basis for separatees.

Operations of the types described above made it seem logical that the revision of AFPDC Reg. 20-19, dated 9 May 1945, apply to this hospital. In this revision, which superseded the earlier regulation, the term "Program Placement and Psychological" was changed to "Psychological Services", and the Branch was taken out of Convalescent Services, put on a par with it and with the other professional services, and made responsible to the Director of Professional Services. Paragraph 2 of this revision, however, stated that the revision does not apply to multi-mission stations such as the Miami District.

Subsequently, however, AFPDC Ltr. 80-56 was received in its revised form, dated 9 May 1945. This directive deals with this Branch as one of the professional services, in line with the revised 20-19, and applies to this hospital. Similarly, the PDC Communique for 31 May 1945, citing Sec. IX, WD Circular 134, dated 4 May 1945, states that psychologists

in AAF Convalescent Hospitals will be responsible to the Director of Professional Services rather than to the chief of another professional service, since their work deals with all types of patients.

In view of the above, on 13 June 1945, the Officer-in-Charge of the Psychological Branch took up the question of the name of the Branch, and its position in the hospital organization, with the Chief of the Convalescent Services Division, who agreed that these were clearly intended to be "Psychological Services Division" in this hospital. The matter was therefore taken to the Director of Professional Services, who agreed to take the matter up with the Commanding Officer. On 20 June 1945 it was learned that the decision had been made to leave things as they were. Although continuing to provide psychological services for a variety of other divisions, the Program Placement and Psychological Branch therefore remains a part of the Convalescent Services Division, with its principal emphasis consequently on the provision of psychological services for that Division.

The internal organization of the Program Placement and Psychological Branch in this hospital has, like that of the hospital itself, been complicated by the number and variety of hospital units, by the changes in the types of patients housed at each unit, and by the distances between these units. The merger of the Regional and Convalescent Hospitals was in reality the addition of a large definitive hospital with a few convalescent patients to a smaller convalescent hospital whose patients were about equally divided between definitives and convalescents. The acquisition of additional convalescent beds with the Surfside and Traymore Unit resulted in a reshuffling of convalescent patients and of those destined to meet CDD or retirement boards, and in a plan to house all medical and surgical convalescents at the new Unit S instead of at Unit T. The decline in the flow of convalescent patients and problems in establishing a convalescent program at Unit S, however, resulted in the indefinite postponement of the latter part of this plan. The surgical equipment of Unit N made it logical to keep that Unit solely for definitive surgical patients, and has kept alive a proposal to move the enlisted severe operational fatigue patients from Unit N to Unit T; but as this would necessitate the transfer of orthopedic patients from Unit T to Unit S, away from the physiotherapy equipment previously installed at Unit T, this plan has never materialized. Each such change, actual and proposed, has had its implications for the location and nature of psychological services, all complicated by distances ranging from approximately three to twenty miles between units.

Processing and Services

In adapting the activities of the Psychological Branch to local needs and desires, the following principles have served as a guide:

1. In a convalescent unit, this Division should in so far as possible operate according to AFPDC Ltr. 80-56.

2. In a definitive unit, this Division should provide such psychological services as are in keeping with the spirit of AFPDC Ltr. 80-56, as are desired by the medical officers concerned, and as will contribute to the effectiveness of diagnosis, treatment, and disposition.

3. In working with headquarters, this Division should provide such psychological services as are requested by headquarters agencies, in particular the Personnel Division and its Branches.

At Unit T (which houses ambulatory convalescent patients of all types except amputees), the application of these principles has resulted in an organization and in services which are similar to those specified in the directives. Even in this unit, however, it was some time before this was true, due to the lack of a personel physician system, to housing facilities which militate against organizing patients for activities on a ward basis, and to lack of support from some ward officers. The chief psychiatrist at Unit T, for example, maintained for some time that his patients, undergoing their first treatment for combat reaction, were in reality definitive patients and would be harmed by psychological interviews and by Orientation III. For some time, therefore, interviews with operational fatigue patients had to be kept on a very superficial level, with no questioning except on vocational and educational matters for program placement, in order to avoid transference. During this same period no operational fatigue patients, mild or otherwise, were enrolled in Orientation III.

After about three months of operating on this basis the confidence of the psychiatrists at Unit T was won, and it became possible to operate according to the directive. The cooperation of the chief psychiatrist was obtained in revising the syllabus for Orientation III, making it less academic at points, eliminating material dealing with marital problems, elaborating on topics which he had at first objected to and which dealt with the psychology and physiology of operational fatigue, and expanding the treatment of problems of readjustment to the States and to return to duty. Since that time all except a very few operational fatigue patients have been enrolled in Orientation III.

It has been the belief of many aviation psychologists that Continuous Orientation (Orientation III, Group Personal Adjustment Conferences), should be conducted, not as a regular class, but rather as an informal therapeutic activity. The trend in this direction has been clear at Unit T, the only unit in which it has been practicable to conduct this activity. Despite this trend, and excellent leadership, Continuous Orientation still resembles a course in applied psychology rather more than it does group psychotherapy. Its planned syllabus, regular number

and sequence of sessions, combination of lectures followed by discussion, and heterogeneous composition tend to make it class-like. The informal atmosphere, attempt to draw out patients, emphasis on content pertinent to convalescent returnees, and an increasing emphasis on the need for the need for the leader to know his patients' names, histories, problems, and interests, are part of the trend toward group therapy.

As Branch personnel acquire more psychological background and more experience in leading group discussion, as psychiatrists become more ready to agree on the values of group therapy, when the flow of patients increases sufficiently to allow the formation of more groups of patients more homogeneous as to background and diagnosis, and as ways are found of overcoming the disorganizing effects of hotel type rooms on group life, it is expected that Orientation III will more nearly resemble the Group Personal Adjustment Conferences described in the newer directives and carried on in certain other AAF Convalescent Hospitals.

Soon after the reinstatement of Continuous Orientation at Unit T, the Unit T psychiatrists requested that the initial interviews, which were being made somewhat more complete as it became clear that cooperation was improving, be expanded considerably in case history form, to assist in the diagnosis of predisposition to maladjustment, and that a test of emotional dependence or immaturity be developed for this same purpose. Work along these lines was begun, and cooperation between psychologists and psychiatrists at Unit T has continued. Few referrals for diagnostic testing have been made by Unit T psychiatrists, but this is due largely to the fact that the combat reaction patients at that Unit are almost all milds who have already twice been screened and who stay in the hospital for only about ten days before returning to duty.

Work with orthopedic and other non-psychiatric patients at Unit T has been affected primarily by the lack of the personal physician system and by hotel-type buildings which preclude an effective ward or barracks organization of patients for group activity. The medical officers assigned to those wards have been primarily orthopedic surgeons or other specialists who, partly because of their specialities and partly because of the large number of patients per doctor, have tended to be more interested in the ailment or injury than in the man. Frequent rotation of personnel has probably contributed to this fact. For these reasons, there has been relatively little liaison with ward officers, and little opportunity or felt need for it. The work of the Psychological Branch with these patients has therefore been primarily evaluation and counseling for program placement, with little clinical study, testing, or counseling except as requested by the patient for educational, vocational, or personal problems.

At Unit B, the small number of convalescent patients, and the pressure to free all beds as quickly as possible for Air Evacuation and definitive patients, has minimized the program placement functions of this

Branch. Although at first one officer and two men were assigned there for evaluation, program placement, and orientation work with convalescent patients, it developed that the program at Unit B needed to be quite different from that in a real convalescent hospital. For this reason the OIC of the Testing Section was made Ass't. OIC of the Branch for Unit B, to operate a much more informal program placement service in the shops and wards as well as in the office. Orientation III was dropped, and a clinically experienced officer was put in immediate charge of an evaluation and program placement program emphasizing the clinical approach to the patient and cooperation with ward officers. This work is being expanded to include definitive psychiatric patients.

The presence of a large number of psychiatric and brain-surgery patients at Unit B made it highly desirable that this Branch provide extensive clinical testing services at that Unit. It was for this reason that one, and now two, clinically trained officers were assigned to the Biltmore, with the part and then full-time assistance of an enlisted clinician. This Section grew to include three full-time enlisted and one civilian volunteer psychologist. As the contributions of and facilities for diagnostic testing have come to be better understood at Unit B, referrals have been made in increasing numbers not only by psychiatrists and neurosurgeons, but also by pediatricians and classification officers.

At Unit N, despite the presence of severe combat reaction and surgical patients, the activities of this Branch have been of a different order. The convalescent program at Unit N, as at Unit B, has been on a small scale. For this reason, only one enlisted man has been assigned there from the Branch, and no officer. This man's role has been that of initial orientation and program placement of all patients referred by the ward surgeons. As in the early days at Unit T, the chief psychiatrist at Unit N has been opposed to contact between psychologists and psychiatric patients, to the extent of ruling out Orientation III on the grounds that the patients are definitive, and of proposing that psychiatrists do all program placement work themselves. Until such a plan is put into effect, the representative of this Branch interviews all convalescent patients for program placement purposes, but takes no case histories. One of the psychiatrists at Unit N occasionally refers patients for mental or personality tests, and these are handled by personnel from Unit T. A plan has now been proposed, by the Chief of the Psychiatric Services Division, for the initiation of clinical psychological services at Unit N comparable to those provided at Unit B.

At Unit S, it was anticipated that a program would be carried on for convalescent medical and surgical patients, for patients awaiting Disposition and CDD Boards, and for men being separated from the service. Since the opening of the unit in Surfside and Traymore Hotels, however, the convalescent census has declined rather than gone up, and for this reason the first part of the program has not been instituted. The only

activity at Unit S has been with separatees. As reported in the section dealing with the separation program, responsibility for the Separation Service has changed hands a number of times, with changing directives and varying interpretations of directives. However, the vocational counseling, including testing, dissemination of occupational information, and interviewing concerning vocational and educational problems, has always been performed by personnel of the Psychological Branch, first under the immediate supervision of an officer of this Branch, then detached from this Branch to the Personal Affairs Branch for the short time, then on loan to the Personal Affairs Branch until it received its complement of personnel for separations work. It is expected that, if this service is to be continued, it will be under the immediate supervision of an officer of this Branch assigned as OIC of the Vocational Counseling Section. This work is carried on by this Branch at the request of the Personal Affairs Branch, because of the superior counseling services which can be rendered by the professionally trained personnel of the Psychological Branch.

At Unit P, the admitting unit for the Regional and Convalescent Hospital, there has been no request for psychological services. Screening of operational fatigue and psychiatric patients is done there by ward officers, with no psychiatric or psychological assistance. This would seem, however, to be a logical place for psychological services, since decisions are made there concerning the seriousness of anxiety states and other problems, and concerning the type of treatment (e.g., intensive psychotherapy or convalescent therapy) needed. Now that the Psychological Branch has approximately its full complement of officers and men, the possibilities might be explored, especially since test construction work has now produced instruments useful in screening. This has been delayed, however, by the fact that the Psychological Branch in thishospital, unlike those in other AAF hospitals, is part of the Convalescent Services Division, with its principal mission in Convalescent Services. The psychological services rendered other divisions have been developed as a result of pressure from without rather than because this Branch has seen possibilities for other types of psychological work and won support for it.

Research

As has been indicated in the section on research, the main areas of research in convalescent hospitals were laid down in the Monthly Research Report of the Psychological Division, AFPDC, for December 1944. In research, as in processing and service, the psychological branches have, however, been permitted considerable autonomy in the choice emphasis and in decisions concerning details. This has been necessary because of diverse local conditions, and wise because of varying talents and interests. The research projects selected at this hospital have therefore been chosen on the basis of the following criteria:

1. Contribution to knowledge or technique in a field important to the operation of a convalescent hospital, as defined by Hq., AFPDC;

2. Practicality at this hospital, with its special types of housing, medical services, and patient flow;

3. Suitability in terms of interests and specialties of Branch personnel.

As insights have been gained into the needs of the local situation and the possibilities for constructive work, different types of research have been initiated. The emphasis early in the history of the Branch was on the two most obvious problems in a situation involving work with many operational fatigue patients, namely, the diagnosis of operational fatigue and the measurement of attitudes toward various aspects of Army life. These efforts were relatively limited in their goals and simple in their approach. The first form of the Convalescent Personal Inventory, for example, asked for only true-false responses, and the attitudes measured in the Patients' Attitude Scale deal with broad categories of attitudes such as attitudes toward the convalescent hospital program, the War, and return to duty. Subsequent efforts have in some cases attempted to use more refined approaches and on others to study more immediate problems. Thus, under the first head, as it became obvious that diagnosis of the degree of operational fatigue is more important in this hospital than decision concerning its presence, the Convalescent Personal Inventory was modified by making it a multiple-choice rather than a true-false test. It was hoped that, by assessing the extent to which a patient had each symptom, rather than merely the number of symptoms he had, a more sensitive measure would be made available. As data are now about to be accumulated for the second form, the hypothesis has not yet been checked. Under the second head, work is being carried on for the development of measures of patients' attitudes toward a number of specific activities and hospital facilities, so that effective aspects of the program can be played up and deficient aspects either eliminated or corrected.

As the local psychological service and research program has matured, the use of more complex methods for the study of more complex problems and the stressing of problems of immediate local importance has increased. The attempt to diagnose predisposition to psychoneurosis by means of a clinical interview, and, building on this experience, to develop a test or inventory for the measurement of predisposition, is an ambitious example of this trend. It is anticipated that this trend will continue.

Certain other types of research have been considered desirable in a convalescent hospital, but have not been attempted. For example, it would be desirable to evaluate the effectiveness of Convalescent Orientation or Group Personal Adjustment Conferences. In view of the varying doubts occasionally expressed about this activity by convalescent

training personnel and by psychiatrists, it would be desirable to have objective evidence not only of its popularity, which is already on hand, but also of its effectiveness in treatment. It would be wise to go further, and to compare the improvement brought about in patients by several types of convalescent orientation, ranging from lectures on appropriate psychological topics to group therapy based on intimate knowledge of the problems of carefully selected groups of patients. The same experimental approach could well be applied to other types of therapy, for example, the improvement resulting from various types of psychotherapy (e.g., with and without pentothal) as compared with that resulting from convalescent "training" in matched groups of mild and severe operational fatigue patients. The first project has not been attempted because of lack of a sufficient number of psychologists with the training and personalities needed for group therapy, the opposition of some psychiatrists to anything smacking of experimentation with their patients, the rapid turnover of patients in some units, and lack of a sufficient number of small conference or discussion rooms. The second type of project has not been undertaken because of problems of introducing experimentation into a service set-up. Both types pf projects would face a problem in developing criteria of improvement, although this could probably be overcome to the satisfaction of most psychologists and psychiatrists if the desire to conduct such an experiment were sufficiently strong.

In conclusion, two major outcomes are expected from research conducted by this Branch:

1. A series of tests of combat reaction, attitudes, mental disfunction and predisposition to neurosis which will be of material aid in the classification, screening, and evaluation of improvement in patients; and

2. A series of studies, some of which will be repeated from time to time, which will throw light on the effectiveness of various types of convalescent training and therapy.

It may seem surprising that little mention is made of the development of instruments for the placement of patients in convalescent activities; that they have not been stressed is due to the fact that experience has shown that interviewing a patient concerning his previous experiences and interests, with the aid of a simple interest check list or inventory, is the most economical and effective method of program placement, and that the greater objectivity of a battery of tests of intelligence, achievement, and interests would not be warranted by the types of problems encountered in helping patients select activities in which they are to engage for only a brief period of time with satisfaction rather than proficiency as the objective. Research is, for the most part, better dorected toward more fundamental and more long-term problems.

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